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PUBLIC HEALTH NURSING

Editor: HEDWIG COHEN, R.N.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

NOPHN Resolves—

We, the members of NOPHN, at this, the 16th Biennial Nursing Convention, by our vote for a two-organization plan for the structure of nursing have reaffirmed our belief in the philosophy and principles on which the program of this organization was founded. We have given the command to carry forward into the second half of the twentieth century the activities of the organization. We have said, in effect, we recognize that society is changing and the way we work together may also have to change. But we have also said, in effect, no matter how we do it, the job of providing public health nursing service to the people must be done, and that this job is not a responsibility of nurses alone but is one shared by all citizens. The following resolutions are submitted in an effort to identify some of the ways that we can carry our share of the responsibility for seeing that the job is done.

1. Whereas, The transition period ahead will be a test of the statesmanship of NOPHN's nurse and general members; and

Whereas, Much personal effort, patience, time, and money from public health nurses and their lay colleagues all over the country will be essential, if important work is carried forward while the new structural design is completed and orderly transition of services is carried out; therefore, be it

Resolved, That the members of the National Organization for Public Health Nursing in the transitional period will give freely of their best leadership and continue their personal and financial support of NOPHN, to the end that a well designed structural plan for organized nursing will be achieved as soon as possible.

2. Whereas, 1950 is the year for the Mid-century White House Conference—whose central concern will be to find ways and means to provide each child with a fair chance to achieve a healthy personality; and

Whereas, The purpose of the conference shall be to consider how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and to responsible citizenship, and the physical, economic, and social conditions which are deemed necessary to this development; and

Whereas, The public health nurse because of close association and professional service to families and institutions working with children makes a unique contribution to the overall program of child health; therefore, be it

Resolved, That the NOPHN through its appropriate sections, committees, member agencies, and individual members prepare to implement the program of the White House Conference as it relates to public health nursing, and also that the NOPHN offer its facilities to all the national nursing organizations to coordinate activities relating to the conference.

3. Whereas, Advances in medical, social, and other sciences are rapidly changing the methods of conserving all aspects of health and of treating disease; and

Whereas, Public health nursing service is experiencing unprecedented demands during a period when the numbers of public health nurses are limited by expanding needs in all fields of nursing; therefore, be it

Resolved, That NOPHN carry its share of the joint efforts of organized nursing to study and improve nursing service, and that it pay particular attention to the identification for public health nursing of those problems on

which special study or research is needed and the development of improved methods for studying these problems, and that it work for expansion and coordination of resources for carrying on studies and research in public health nursing and for testing out, in actual practice, the results obtained.

4. Whereas, Nursing is an essential part of complete medical and health care; and

Whereas, For more than ten years the NOPHN and ANA have been promoting the inclusion of nursing benefits in prepayment plans for medical care; and

Whereas, Very few of these plans make provisions for adequate nursing service; therefore, be it

Resolved, That the NOPHN join with the ANA in requesting the cooperation of the American Medical Association and other professional and health organizations in bringing about the inclusion of nursing service in medical care plans; and be it further

Resolved, That the membership make use of the Guide for the Inclusion of Nursing Service in Medical Care Plans.

5. Whereas, Public health nursing education and public health nursing service have a mutual interest in developing public health nursing personnel of the best possible quality; and

Whereas, Facilities for education and personnel for service needs can best be provided through cooperative effort expressed in long-range planning in geographic areas with common problems and needs; therefore, be it

Resolved, That NOPHN assume leadership for experimentation and the development of technics for regional planning which will result in more effective use of educational resources and more adequate supply of qualified public health nurses.

6. Whereas, The public health nurse renders an essential service to society; and

Whereas, Her education, to be effective, must include field instruction, which often requires expense not usually considered a part of educational costs, such as ownership of an automobile; therefore, be it

Resolved, That NOPHN uphold the principle of tax support for public health nursing education, and exert every effort to secure such support through whatever channels are available; and be it further

Resolved, That NOPHN lend its support to find methods to provide transportation for rural field instruction.

7. Whereas, Maternity care which focuses interest on the family can make a contribution to health as a unifying world influence; and

Whereas, Administrative convenience, technics, and the teaching of professional personnel seem to hold the center of interest today; therefore, be it

Resolved, That the NOPHN recognize the following as a basic principle of maternity care: That maternity care must be satisfying alike to the mother, her husband, and the professional personnel; and That, to achieve this, the focus of interest must shift from administrative convenience, medical and nursing education, hospital and professional economy, to the mother and her family; and That a change in emphasis is indicated in teaching, in technics, in attitudes, in administration, and in relationships between all community agencies to secure family-centered maternity care.

8. Whereas, Elizabeth Gordon Fox has provided outstanding leadership in nursing, not only in her local community and state, but also nationwide; and

Whereas, Her work in the American Red Cross Nursing Service after World War I promoted and influenced the development of public health nursing services; and

Whereas, She served as president of NOPHN, and was an active and helpful member of many committees; and

Whereas, She made an exceptional contribution in interesting laymen in nursing, particularly in public health nursing; and

Whereas, She has, throughout her professional life, contributed articles to our professional publications which have been notably stimulating, timely, and helpful in defining and clarifying issues, and in offering patterns for healthy relationships and developments; therefore, be it

Resolved, That the NOPHN in convention assembled do acknowledge with gratitude the outstanding leadership, the challenges, and

the services of Elizabeth Gordon Fox to nursing, especially to public health nursing; and be it further

Resolved, That this resolution be spread upon the minutes; and be it further

Resolved, That a copy of the resolution be forwarded to Miss Fox.

9. Whereas, Katharine Tucker, past president of NOPHN, and for six years a distinguished general director at headquarters, has now retired from active nursing; and

Whereas, Miss Tucker's leadership in nursing during more than thirty-five years has been eagerly followed and deeply appreciated by her colleagues; and

Whereas, Her contribution to the advance of the objectives of NOPHN through her administration of a voluntary public health nursing agency greatly facilitated the National Organization's progressive expansion in service and program, contributing likewise to similar growth in other parts of the country; and

Whereas, Her constant efforts for the improvement of educational opportunities for the preparation of nurses in public health nursing contributed in no small measure to the skill of countless practitioners, supervisors, and administrators in her chosen field through her long years as chairman of NOPHN's Education Committee, and more recently her directorship of a university department of nursing education; and

Whereas, Her creative vision, constructive planning, and broad concept of the place of public health nursing—in fact, of all nursing—in the national and international health program caused her to be repeatedly sought as consultant, adviser, and committee chairman by her own and other professions in joint undertakings; and

Whereas, As chairman of the Advisory Committee to the Procurement and Assignment Service of the War Manpower Commission during World War II, through her energy, wisdom, and high qualities of leadership she made a contribution to the war effort far beyond the call of duty; and

Whereas, Her keen awareness of the essential parts which citizens are called to play in any sound health service led her to seek and develop lay counsel and participation in each of the wide range of areas of her service; and

Whereas, Her high respect for the integrity and rights of individuals enabled her to bring forth in colleagues, associates, and students evidence of growth and ability to progress above personal anticipation; and

Whereas, Her unique gifts of constructive thinking and clear portrayal, combined with an unusually broad fund of knowledge and mature judgment generously shared through the spoken and written word, brought her own individual contribution to public health nursing to countless nurses in this and other lands; and

Whereas, Her delightful sense of humor will cause her to view these expressions with a twinkle as well as with understanding and appreciation of their sincerity; therefore, be it

Resolved, That the NOPHN assembled at its 1950 Biennial Convention express gratitude and admiration of her distinguished influence upon the advancement of public health nursing in its service to families; and be it further

Resolved, That this resolution be spread upon the minutes; and be it further

Resolved, That a copy of this resolution be sent to Miss Tucker, assuring her of our high resolve to carry forward toward the goal of health for the American people along which path she has enabled us to make enduring progress.

10. Whereas, The leadership of NOPHN during the past biennium has called for great wisdom and objective thinking; therefore, be it

Resolved, That we extend to Ruth W. Hubbard, our retiring president, our deep and heartfelt thanks for providing that kind of gifted leadership. Her graciousness and sincerity in the face of unusually heavy demands, and her willingness always to help those who sought her assistance, have inspired all of us. To Anna Fillmore, general director, and to the members of the NOPHN professional and business staff for their devoted service in the face of constant pressures of work, we also extend sincere thanks.

11. Whereas, The public health nurses in the Territory of Hawaii have long been a component part of the National Organization for Public Health Nursing; and

Whereas, Our members in Hawaii are strongly desirous of joining us as a state; therefore, be it

Resolved, That the National Organization for Public Health Nursing in convention assembled ask those of its members who wish to support the efforts of Hawaii for acquiring statehood to write immediately to their Congressmen to this effect.

12. Whereas, Planning and managing a large convention represents a sizable investment of time, energy, thought, and imagination on the part of a great many people; therefore, be it

Resolved, That we, the members of NOPHN, extend our thanks to all those who contributed to the success of this, NOPHN's twenty-second convention—the California State Nurses' Association, the California State League of Nursing Education, and the California State Organization for Public Health Nursing, the Local Arrangements Committee and subcommittees, the Convention Bureau staff, ushers, monitors, messengers, exhibitors, and representatives of the press; and be it further

Resolved, That we thank also the agencies which made it possible for staff members to attend the meetings and the individuals who presented papers and reports. We extend a note of thanks also to all the members and local florists who contributed generously of California's floral beauty, which did so much to add color to the meetings and gladden the hours spent in deliberations.

RESOLUTIONS COMMITTEE
PEARL PARVIN COULTER, R.N., Colorado
EVELYN ELLINGSON, R.N., California
HELEN L. FISK, R.N., Maryland
GERTRUDE GRAWN, Michigan
RENA HAIG, R.N., California
GERALDINE HILLER, R.N., Massachusetts
MARGARET SHETLAND, R.N., Michigan
MARTHA D. ADAM, R.N., California, *Chairman*

NOPHN Elections

EMILIE G. SARGENT became president of the NOPHN for the coming biennium at the close of the 1950 convention. Miss Sargent, an experienced administrator, succeeds Ruth W. Hubbard, president since 1946. Miss Hubbard has given distinguished service to the organization and to nursing during this period. Her graciousness, wit, and charm, her intellectual keenness and ability to cut through the problem to the core, have been evident throughout her period of leadership in the organization. It is a pleasure to announce that Miss Hubbard has been elected to the Board of Directors and will continue to share with us her clear thinking.

Miss Sargent has long been active in NOPHN affairs, having served as a member of the Board of Directors and as first vice-president. During the past biennium she has been chairman of the Committee of the ANA and NOPHN on Nursing in Medical Care Plans and chairman of the NOPHN Committee on Cost Analyses. Miss Sargent is also a member of many other national, state, and local committees. She is executive director of the Visiting Nurse Association, Detroit, Michigan.

In 1946 Miss Sargent was awarded the honorary degree of Doctor of Science in Nursing by Wayne University. The citation given her at that time described so well her

contributions and abilities that we repeat it here in part: "One of the Country's ablest nursing administrators, an authority on prepayment plans for nursing service, an able leader in programs and recruitment of war and civilian nurses, and an expert counselor for young nurses, she has developed an outstanding training center and one of the finest visiting nurse programs in the world. The health and welfare of the community have profited immeasurably by the development of this efficient and humane organization under her farsighted leadership." The membership of the NOPHN welcomes Emilie G. Sargent, its president.

Others elected for the coming biennium are: Dorothy Wilson, New Haven, first vice-president; Mrs. H. Stanley Johnson, Madison, Wisconsin, second vice-president. The following are the newly elected members of the board: Helen M. Fisher, Portland, Oregon; Ruth B. Freeman, Washington, D. C. (formerly first vice-president); Ann Hauser, Minneapolis; Lucile Perozzi, Denver; Mrs. Edward H. Bryson, Richmond, Virginia; Dr. E. F. Daily, Washington, D. C.; Dr. Paul V. Lemkau, Baltimore; Mrs. Robert B. McIver, Jacksonville, Florida; Dr. Henry T. Moore, Saratoga Springs, New York; Dr. Ruth R. Puffer, Nashville, Tennessee; and Mrs. Edward N. Torbert, Boise, Idaho.

The following were reelected: Anna Fillmore, secretary; Mr. L. Meredith Maxson, treasurer, and Mrs. William B. Cook, Seattle, Washington, board member.

A complete list of the present Board of Directors appears on page A4.

At the Biennial Emilie G. Sargent, (right) and Dorothy Wilson, newly elected NOPHN president and vice-president.

THE BIENNIAL CONVENTION

"Consolidation of Nurses' Organizations Gets First Vote of Approval"—This headline in the *San Francisco Examiner* introduced a newspaper story that "the first official vote on the controversial question of change in the structure of the six national nursing organizations was reported [May 10th] by the National Organization for Public Health Nursing." The interest of all the local newspapers in what the nurses did and said at their convention was notable. It made us realize again something we ought not to lose sight of, that the consumer public wants to understand our problems and activities; the public wants to understand nurses and work along with us.

STRUCTURE

Undoubtedly structure took the limelight at the convention. The first NOPHN business meeting opened with a roll call to which representatives from forty-two states and Hawaii responded. About 700 members were present. The question of structure appeared early on the agenda. Anna Fillmore, general director of the NOPHN, reported on the recent poll of the membership. Forty percent of the 7,800 questionnaires were returned and a large majority of these indicated preference for a two-organization plan. Some stated they hoped *eventually* there could be one organization for all nursing. Among those who voted for one organization *now,* many added the proviso, "if lay members could be included." A small percentage voted for no change.

A summary discussion of structure was presented by Hortense Hilbert. Miss Hilbert commented that structure is not only biennial but also perennial. She traced the history of the formation of new organizations during the early part of the century when special needs existed and counseled that it is wise to look backward as well as forward to make sure we do not leave behind usable ideas. Reorganization is *not reshuffling* of the present six organizations but something new and bigger that will allow nursing to present a unified front.

At the close of this presentation many members spoke from the floor. Several nurses expressed concern that provision be made for lay membership in whatever structure is decided upon.

THE SECOND business meeting convened at 2:00 p.m. on Tuesday, May 9th. As soon as the meeting was called to order and it was ascertained that a quorum was present, a member rose, was recognized by the chair, and presented the following: "I move the NOPHN membership vote for a two-organization plan." This was seconded and the call for the question was voiced immediately. The vote was overwhelmingly in favor of the motion. Thus, within five minutes after the opening of the meeting the decision for the NOPHN had been made by its membership present in convention!

On Thursday at the meeting of the ANA House of Delegates a majority vote was also cast for the two-organization plan for reorganization. This decision had already been made by the membership of the NACGN. The three remaining organizations, the AAIN, the ACSN, and the NLNE, will shortly secure mail votes on this question. There is every reason to anticipate that these memberships also will cast majority votes for the two-organization plan.

All that has happened concerning structure has been a great rehearsal. We enter immediately into the interim stage where the design for the two new organizations must be completed and bylaws formulated and acted upon by the membership of each of the six nationals. Further special guidance must be secured, also, to care for the many legal aspects of merging six active national bodies into two new organizations, and an orderly plan for transition of the six into the two must be evolved. We can look back with pride to the accomplishments of the last six years—it is no little thing we have achieved, to reach agreement on a way of amalgamation—but the future carries an even greater challenge: It is the period for action—carefully thought out and executed, not overnight, but in whatever time may be necessary to safeguard and carry on all that is vital and fundamental in the current programs, and at the same time move as rapidly as possible into new patterns to meet new needs of nurses and nursing.

NOPHN PROGRAM 1950

To return to the NOPHN business meeting: Miss Hubbard who presided said, "The job really begins now for all of us. It is particularly fitting that as we move into the design for 1950-1952 we review the aims and objectives of our organization, around which the NOPHN program for the coming biennium has been tentatively set up."

She read the five objectives stated in the NOPHN's charter, and described in relation to each one the current program activities and several new ones contemplated for the coming biennium.

Since few in the audience had had the opportunity to consider the proposed program, copies of which were distributed, the members were asked to study the material and mail comments and queries to headquarters. If you are interested, will you write for a copy and let us have your suggestions also?

Certain specific questions and resolutions were presented for action.

Moving headquarters: It was voted to retain NOPHN headquarters in New York. (The ANA House of Delegates also voted to retain ANA headquarters in New York.)

Revision of bylaws: The members voted to accept the proposed revisions. (See PUBLIC HEALTH NURSING, March 1950.) The amendments concern primarily the time of the meeting of the Council of Branches, and agency membership dues in communities where a quota plan for the payment of national agency dues is in existence.

Inclusion of nursing in medical care plans: It was voted to promote the inclusion of nursing in medical care plans. (See resolutions, page 367)

Mabel Reid gave a report on the new method of cost accounting. In this she reviewed the historical background of this work as well as developments in cost analysis methods over the years. (See page 409)

Combination services are drawing greater interest each day. Dorothy Rusby, who is completing a report of a six-month study of such services, told about her findings at the business meeting. There were many thoughtful questions asked from the floor. Undoubtedly Miss Rusby's report will prove popular reading. We hope to announce its availability soon.

Miss Fillmore told of the interest in and need to carry on studies and research. At the request of the ANA Board, the Joint Board Steering Committee recommended that the individual boards appoint a joint committee on research and studies. This committee is to prepare a statement of philosophy and a plan of action concerning the way in which research in nursing can be stimulated, conducted, and reported, and also to suggest studies for the immediate future. In public health nursing we must first identify problems requiring study. Second, we must help develop methods for conducting studies. Third, we must carry out and evaluate studies. The entire field of research will be given priority consideration in the coming biennium.

RALLY

The NOPHN rally, an opportunity for members and their friends to get together for dinner, fun, and frolic, was a truly convivial occasion. At each Biennial, the rally calls forth the essence of *esprit de corps*. What

made the 1950 rally an especially happy one is difficult to say. Was it the hard work and careful attention to detail of the local committees? Was it the Costa Rican trio who knew exactly the right tunes to play? Was it the roast beef and extra-special ice cream dessert, the lovely flowers, the generously contributed favors? Or was it the familiar faces of friends of long ago and coworkers of yesterday? In addition, several gifted members from San Francisco delighted us with a one-act presentation about what some other people think about us. (See page 418)

Mrs. Fannie Warncke was a charming mistress of ceremonies who kept things humming, and just about everyone said this was the best rally ever!

SECTIONS' PROGRAMS

The rally was a pleasurable interlude in a week of serious business. As usual, the NOPHN sections planned educational programs. This year the Board and Committee Members Section, the Collegiate Council on Public Health Nursing Education, and the School Nursing Section jointly sponsored a panel discussion on "teamwork in the home care of the cancer patient." Papers based on this will be published in the September issue of PUBLIC HEALTH NURSING. Dr. Howard Y. McClusky, consultant in community adult education at the University of Michigan, was chairman and he and the eight discussants gave a most inclusive presentation. The cancer patient who returns to his home from the hospital needs expert nursing care. In addition, he usually presents other problems which can best be solved through the close working together of doctors, nurses in the hospital, public health nurses, and medical social workers. The volunteer, who may be an inactive nurse, finds a wide field for her services working with cancer patients.

THE BOARD AND Committee Members Section also arranged for two other programs: a panel discussion on citizen participation in public health nursing and a cooperative case presentation on community nursing and the handicapped. Mrs. E. C. Sage, chairman of the lay section, California SOPHN, presided at the panel An enthusiastic audience carried on lively discussion for almost an hour following the papers.

Dr. Dorothy Nyswander in discussing opportunities for citizen participation asked, "Why make the effort to join with others in some social endeavor?" She answered her own question most satisfactorily. The main reason is "that we now know that working with others in committees and organizations is a kind of insurance for good mental health in adult life. Group work appears to be an antidote for stagnation and futility."

Mrs. Eleanor S. Mosher, also on the panel, said, "Volunteers is the word I like to use. The volunteers impose their own obligations, work without coercion, without pay or reward, with the professional staff to promote effective and productive functioning of the service for the cause of human progress. The keynote of the philosophy lies in the words *work with* not *work for*." Mrs. Carl B. Grawn, talking about responsibilities of board members, said, "Our biggest contribution often is in interpreting the agency and winning friends for it. To interpret means to understand the work, objectives, history, the significance of relationships with other groups. . . . It requires preparation and constant awareness of shifts in activities." Mrs. Russell T. Uhls, the last discussant, described the organization of the Citizens Advisory Committee, Bureau of Public Health Nursing, Los Angeles County Health Department. Mrs. Uhls listed hints for a successful volunteer program. She counsels last—but not least—give recognition in a tangible form.

The panel papers will appear in PUBLIC HEALTH NURSING in September. We also plan to publish some of the material given at the case presentation at which Dr. Sydney S. Norwick, regional medical director, Office of Vocational Rehabilitation, FSA, was moderator. The family discussed had been carried by the Visiting Nurse Association of San Francisco for a long period, and it was especially interesting to find how much of the story was based on the nurses' records.

The Nurse Midwifery Section discussed "changing maternity service in a changing

world." The section chairman, Helen L. Fisk, presided. Papers were presented by Hazel Corbin, Verda F. Hickcox, and Margaret Brooksbank, a Nightingale scholar from Liverpool, England. These papers were discussed by a group led by Hattie Hemschemeyer, and also drew many questions and comments from the audience. One nursing administrator said, "What we have heard today is significant for all of us. Every administrator, every educator, should return to her institution or agency determined to revise the curriculum and services on the basis of the philosophy discussed here today." The three main papers will appear in the next issue of the magazine.

Detailed reports of the NOPHN sections' activities during the convention will be published in the August issue.

THE HOUSE OF DELEGATES

The 1950 House of Delegates set a remarkable example for all of us. Faced with a detailed and lengthy agenda the delegates stayed closely to the topics under debate, showed mature discipline in their discussions, and completed their assignments in the time set for them. There was always an interested alert gallery present during the house sessions, and undoubtedly it was difficult for many among the observers to keep out of the thick of things. Anyway, there were outbursts of applause from the gallery, which must have helped strengthen the delegates during the long hours of hard work they gave to their job.

The action of the House of Delegates on structure has already been reported. Local delegates will give—or already have given—personalized accounts of the sessions, and therefore a detailed report will not be offered here. The house was faced with several knotty problems, and following are some of the decisions reached.

Associate membership: It was decided to admit as associate members nurses who have withdrawn from active nursing and who have worked more than thirty days in the current year. Dues were set at 75 cents a year. This move will permit thousands of nurses who drop out of nursing each year because of marriage, retirement, et cetera, to retain their interest in nursing and nursing standards.

Strike conduct: Statements were adopted covering the conduct of nurses engaged in negotiations with their own employers, nurses employed in plants where strikes occur, and nurses in institutions where nonnurse employees strike. The ANA endorses a ***no strike policy for the conduct of economic security programs*** by state nurses associations. Nurses should maintain a neutral position in regard to labor-management relationships between their employers and nonnurse employees.

Health insurance: A request from the American Medical Association that the House of Delegates adopt a resolution condemning compulsory health insurance was tabled. The discussion on the floor indicated a difference of opinion among the delegates on the subject. It also indicated strongly that American nurses desire to be able to nurse anyone who needs them in any situation whatsoever. The delegates voted to ask the American Medical Association and other recognized national professional and health organizations to work jointly with the ANA for the inclusion of adequate nursing services in voluntary nonprofit prepayment plans.

Study of nursing functions: The ANA Board of Directors presented to the House of Delegates an outline for a five-year plan to study nursing functions. The proposal is to limit the study at first to institutional nursing. The study aims (1) to find out what functions are being carried out by each group of nursing personnel (2) to suggest which functions should be performed by various nursing groups—new functions as well as reallocation of present functions (3) to test in actual hospital situations the suggested reallocation of functions (4) to decide on the effectiveness of the reallocated functions and (5) to prepare a manual as a guide for individual institutions.

In carrying out the program the ANA Board recommends that SNA's be asked what they consider to be problems and how they would propose to meet these problems. Proposals from the states are to be considered by a committee in relation to the purpose and objectives of the total program. If study by any

state would contribute to the objectives of the total program funds would be allocated back to the respective state to carry out the specific study. All parts of the study would be coordinated and directed to the total program. The House of Delegates voted in favor of financing this study. Each SNA will decide how its share of the overall costs will be raised.

GENERAL MEETINGS

Joint program meetings—traditional at biennial conventions—were held Monday, Wednesday, and Thursday evenings. The large arena was crowded on each occasion. Mrs. Olive W. Klump, president of the California SNA and member of the NOPHN Board of Directors, delivered the address of welcome on the first night. Her warm gracious words struck a note of Californian hospitality echoed throughout the week by all the California nurses. Mrs. Klump said, "Things which bind us together as nurses are stronger than things which divide us." Certainly everything that happened during the convention week proved her point.

Dr. Stafford L. Warren, dean of the School of Medicine, University of California, L. A., spoke on "health—a unifying world influence; nursing accepts its role." He said nurses are considered solid disciplined people and as such have a stabilizing influence on their communities. He described what can be expected if another war should come and bring in its wake atom bomb casualties. Such a disaster will need disciplined people trained to help the wounded. (Editorial comment: It would also seem a vision of such a disaster would activate disciplined people to strengthen the United Nations and cooperate in other educational and cultural activities so that future wars can be prevented. There never has been a time in which it is more important for us to identify ourselves with what Walter Lippmann calls "the probability and the hope of peace.")

ON WEDNESDAY night Dr. Baldwin M. Woods, vice-president, University Extension, University of California, Berkeley, discussed "integration of general and professional education in nursing." He discussed basic issues similar in education for all professions and said that professional education must be a continuous lifelong experience. The speaker Thursday night, Dr. Norman Reider, director of Psychiatric Department, Mount Zion Hospital, San Francisco, talked about "human needs and nursing." (This paper appears on page 388.) Although Dr. Reider discussed problems and reactions of student nurses his point can very well be applied to graduate nurses also. Anything that will help us understand our coworkers helps us understand our patients.

On Tuesday night the *American Journal of Nursing* celebrated its fiftieth birthday. The arena was bursting at its seams with well-wishers. They were treated to a brilliant pageant, The Challenge, and lovely music. Later Lieutenant General Albert C. Wedemeyer, Commanding General, Sixth Army, spoke on "woman's role in national security." The general said the targets of phony wars are people's minds and hearts. Military forces alone will not suffice in winning wars; modern weapons are inadequate. We must seek a common ground for political, economic, and cultural collaboration. We must fight in the realm of the mind. As American women we must insist that our government give us factual information and that "an important factor is to assure that the formulation of our future policy is in consonance with the will of the American people."

At this celebration the establishment of the Mary M. Roberts fellowship in honor of the editor emeritus of the *Journal* and a long-time friend of all nurses was announced. (See page 422)

NLNE PROGRAM MEETING

At the NLNE meeting on May 11th Dr. Genevieve K. Bixler presented a discussion, "how can research in nursing assist in the clarification of issues now before the nursing profession?" Dr. Bixler said, "What is an issue but an unresolved problem about which there is a cleavage of opinion, some different points of view among the persons who have common interest in the problem? The dif-

(Continued on page 387)

THE CARE OF THE PATIENT WITH CANCER

MARY G. PATTERSON, R.N.

When the public health nurse knows what happens to the cancer patient in the hospital, her understanding of his total experience with his disease is deepened and she is better able to help him.

CANCER HAS NOT always been considered a public health problem. The main focus of public health activity up until the 1940's has been the fight against those diseases which it was known could be controlled by environmental management. It is perhaps a tribute to the success of these efforts that the problem of cancer has emerged as an urgent matter of community concern.

How can we account for the fact that among all diseases causing death in the population as a whole cancer today ranks second? One factor is the changing age composition of the population. While in 1900 approximately 8 percent of the population was over 45 years old, by 1940 the percentage had increased to 32. What is more, it is estimated that by 1980 over 58 percent will have passed this age. The significance of this fact is appreciated when we study the mortality statistics in cancer by age groups. Here we see that the rate of 60 deaths per 100,000 at 40 years of age increases sharply to 1,200 per 100,000 at 80 years of age. This tremendous increase projects the problem into the realm of community responsibility and upon the shoulders of the public health nurse. The individual on the threshold of 40 steps into the "cancer age," the period of everlasting cancer awareness. But life is complex. Nursing problems originate as much from the age of the patient, his attitudes, social milieu, economic resources, and potential and correlated physical and emotional dysfunctions, as from the specific nature of the tumor. The public health nurse finds herself projected into the multiple problems of the aged when caring for the individual who has cancer, for it is true that the main problem occurs in this section of the population.

However, a cancer may start to grow at any time of life. It is not generally recognized that malignant neoplasms, which include leukemias and Hodgkin's disease, rank second as a cause of death from ages 1 to 14 years. These tumors are, for the most part, congenital in nature and pursue a chronic course. Therefore, the incidence is greatest in the first four years of life, but it is the first cause of death from ages 5 to 9. Many factors account for this. The most important, perhaps, is the greatly decreased incidence of communicable and infectious diseases and, indeed, in some instances their practical disappearance. To this picture must be added the improved treatment which has even more favorably modified the mortality rates than

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has decreased incidence. On the other hand, due to increased awareness and improved diagnostic methods, the incidence of cancer among children has seemed to increase, and unfortunately, in this age group the mortality rates have not yet been materially affected by treatment. These facts have special significance for public health nurses who are case finders in their infant care, preschool, and school health programs. What tremendous significance and satisfaction there are to the alert nurse who suspects early disease in her physical inspection and is instrumental in obtaining successful treatment. Indeed, as we inspect the entire incidence picture we must conclude that it behooves every nurse always to keep her eyes and her thoughts "cancer conscious."

A cancer, or more accurately a malignant neoplasm, not only may develop at any time of life but may originate from any tissue in the body. Malignant cells originate from a normal cell which, for some reason, has become immune to those controlling factors which produce a normal pattern of development. If we clearly understand this then we can see that every malignant neoplasm starts as a localized process. Some people develop multiple primary lesions or more than one localized process at a time. From the point of view of treatment this is an extremely important fact to determine. As long as a neoplasm remains local, treatment for cure may be undertaken. The term local in this case may refer to a complete absence of metastasis, or to a process confined to a specific anatomical region, such as leg, arm, breast, pelvis, stomach, et cetera. The vital importance of helping the patient obtain an accurate diagnosis and adequate treatment as early as possible becomes obvious. There is no objective study of results which does not demonstrate the high correlation between the effectiveness of treatment and the stage in the development of the cancer when it was instituted.

As we study the incidence statistics for malignant neoplasms further, we find that most tumors occur in relatively few anatomical sites—a fact which should make it easier to find them earlier.

In men, 36.4 percent of all tumors occur in the gastrointestinal tract (mainly the stomach and the rectum) 17.4 percent on the skin (usually on areas exposed to weather and clearly visible to the eye) 11.6 percent on the genitals (correlated to phimosis and lues and also visible and palpable) and 10 percent in the mouth and pharynx (an equally exposed area of the body). In these four sites 75.4 percent of all tumors which occur in men arise.

The picture varies in women. Here we find that 23.7 percent occur in the breast and can be felt, 22.9 percent occur in the gastrointestinal tract (again chiefly in the stomach and rectum) 21.7 percent in the uterus (chiefly on the cervix and visible to inspection as well as available for diagnosis by exfoliative cytological study) and 11.4 percent on the skin (again in visible areas). These four sites give rise to about 80 percent of all tumors occurring in women.

The public health nurse who wishes a guide by which to recognize the early signs of cancers arising in these sites can profitably use the "Seven Danger Signals" of the American Cancer Society.

1. Any sore that doesn't heal, especially on the tongue, mouth, lips, or skin.
2. A painless lump or thickening, especially in the breast, lip, or tongue.
3. Irregular bleeding or discharge from the nipple, nose, vagina, or any body orifice.
4. Change in color, size, or character of any wart, mole, birthmark, or pigmented area.
5. Persistent hoarseness, cough, or difficulty in swallowing.
6. Persistent indigestion or change in appetite.
7. Any change in the rhythm of normal bowel habits toward either constipation or diarrhea.

Every individual with any one or combination of these signs should be referred to his doctor for investigation.

The public health nurse must know that the pattern of occurrence in children is somewhat different but is characteristic and common to both sexes. The six most common sites affected according to importance are the central nervous system, bones, eyes, kidney,

blood and lymph, and skin and supportive tissues. The signs in youngsters which should alert the nurse are listlessness, any unexplained behavior changes, stumbling, poor coordination, headaches, asymmetrical development. It certainly would not be amiss to look for an enlarged abdomen and feel for the presence of a lump. Pink toothbrush, unexplained temperature elevations, pallor, or any tendency to bleed should be immediately reported to the doctor.

ONCE THE PATIENT is under medical care, helping to prepare him for necessary, trying, expensive, and time-consuming diagnostic procedures is a challenge. In addition to a complete physical examination, routine blood work, x-rays, et cetera, making a diagnosis involves an inspection of the lesion and a biopsy for pathological diagnosis with or without benefit of "——scope," knife, needle, et cetera. It is important to recognize that the patient's basic attitudes toward the subsequent treatment of his disease, motivation to rehabilitation, acceptance of help from doctor, nurse, and others upon whom he will be necessarily, if temporarily, dependent, are all conditioned by these initial experiences. Today we recognize more clearly than ever how important a factor this may be in determining the eventual outcome.

The patient who comes for diagnosis and treatment feels frightened; he may feel sick. The possibility that he may have the dread disease is always present, whether or not the doctor refers to it as a tumor, mass, growth, or in more technical terms. The extensive public education programs of the cancer societies in the last few years have had their effect, and many laymen are well informed on the subject, bringing more specific information to the situation than is usually realized. However, this knowledge does not always signify an understanding of the problem. In addition, under the stress of illness the patient becomes childish in his reaction and feels as dependent on the doctor and nurse as he would upon his own parents. He wishes to be sure that, like a parent, the nurse is concerned with him as an individual and that he will be liked no matter what. At the same time he may blame the nurse for all the misfortune which has befallen him and express to her his resentment, hostility, and distrust. Reassurance is conveyed to him more by attitude, feelings, and competence than by the exact meaning of what is said.

In general, it is believed that the word "cancer" should be avoided because it is such a scientifically inaccurate and misleading term. Most people associate it with repulsive odors, sloughing ulcers, disfigurement, intractable pain, and fatal outcome. It is true that many cancers are rapidly growing and fatal in a short time, but the patient may live with others for twenty to thirty years and then succumb to some other disease. What is more, due to earlier, more accurate diagnosis and more adequate treatment the picture becomes more and more hopeful. In Connecticut, for instance, the five-year survival rate of women after treatment increased from 25 percent in 1935 to 39.6 percent in 1941. It seems, however, that the time when the patient is sick and getting treatment is hardly appropriate for a discussion of where he fits into this picture but to convey the hopeful and optimistic attitude we all must have.

The medical plan for treatment may include radiation, surgery, or a combination of both. The use of hormones or chemotherapeutic agents is still largely in the experimental stage.

Radiation of the tumor may be achieved through the media of x-ray therapy, radium applicators, bombs, needles, et cetera, radon seeds or radioactive isotopes. X-ray therapy is the most common method used in this group. The effect of radiation on the tissues is cumulative. The maximum therapeutic effect is obtained by a careful fractionation of the dose at specified intervals over a limited period of time. Understanding this, the public health nurse can help her patient appreciate the importance of keeping all appointments and completing his treatment, even though the treatments may have made him temporarily ill. Indeed, help should be arranged if possible for necessary assistance such as transportation, housing, and the like. X-rays are aimed to destroy the tumor but also of necessity they affect all the overlying

tissues through which they must pass, especially the skin. The care of the exposed skin is most important because its ability to survive the radiation may determine the dose which can be delivered to the tumor and, therefore, eventual success or failure of the treatment.

The two principal objectives in the management of skin reactions to x-rays are to protect it from trauma and infection. Soap, water, lotions, creams, oil solvents, or oils themselves should be avoided. Pure corn starch may be applied to folds of skin or surfaces which brush one another in movement such as the inner aspect of leg, breast folds, et cetera. The area should be exposed, omitting the application of dressings and bandages which often produce irritation and reduce circulation. The skin should be protected from sun exposure, ultraviolet, infrared, or any heat lamp, extreme temperatures, and mechanical irritants, such as belts, elastics, brassiere straps, tight shoes, tight hat bands, stiff collars. If vesication occurs and the area becomes weepy it should be scrupulously protected from infection with dry sterile dressings. It is always important to remember that this tissue has reduced healing capacity due to reduced blood supply and may quickly become necrotic.

Systemically, an increased fluid intake helps to reduce the toxic effect of tissue breakdown. Malnutrition and dehydration due to nausea, vomiting, diarrhea, loss of appetite, are stubborn and challenging problems. Since many patients are already nutritionally debilitated when treatment starts, such an additional loss further inhibits the recovery of the normal tissue after the tumor has been destroyed. Food which is attractive, simply prepared, served in small quantities at frequent intervals, may be more acceptable. Pyridoxine, dramamine, or even hydrochloric acid may be prescribed to be taken before meals to stimulate the appetite and digestion. Many doctors feel quite strongly, however, that the gastrointestinal symptoms are in part a reaction of the patient to the suggestion that he is expected to be ill in this way. It is well to wait for the patient to initiate a discussion of his problem rather than to suggest discomfort by leading questions.

More and more we see the entire plan for treatment including both radiation and surgery. Indeed, the newer and more demanding problems of nursing care today lie in the field of surgery. As long as the disease remains localized the surgeon has his opportunity to cure the patient. Tumors are malignant when they grow into or infiltrate adjacent tissues. The cells which are washed off in the circulating blood or lymph can grow in another part of the body, forming a metastasis. Lymph-borne metastases at first are local because they are dammed up by the regional nodes. Therefore, surgery for a malignant neoplasm is very radical because the surgeon attempts to get entirely around the tumor, taking in continuity a margin of apparently normal tissue and also the draining lymphatics. The patient may be left with disabling and ugly defects. To some extent each operative result presents special nursing care problems. The radical mastectomy and the colostomy are two of the most common in the experience of public health nurses.

A radical mastectomy consists of the resection in continuity of all the breast tissue, underlying muscles, and axillary lymphatics draining the area on the affected side. Since these lymphatics also drain the arm, one of the most disheartening sequellae of this operation is the lymphedema of the arm. Some doctors feel that starting arm exercises the day after operation helps to develop new lymph channels and prevents the accumulation of fluid in the extremity. The nurse plays an important role in encouraging the patient to plan and carry out an exercise routine which will not only restore the arm to normal function but also will prevent a general postural defect due to removal of the pectoral muscles.

Meanwhile, from the moment of discovery of the lump the patient has been concerned about how she will look when it is all over. In our society the media which mold our cultural attitudes, such as the movies, newspapers, magazines, et cetera, have placed so much emphasis on the basic importance of personal appearance to any woman's success that a woman with one breast becomes a monstrosity. The public health nurse must be extremely sensitive to and understanding

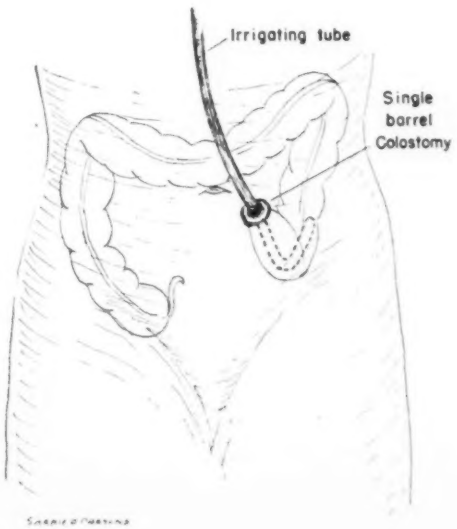
of the patient's feelings in this situation and can mitigate this concern by reassuring the patient that the nature of her operation can remain her own personal affair as far as the public is concerned. It is possible to show her how to pack the unfilled cup of her brassiere with cotton in such a way that she will look perfectly symmetrical. This type of prosthesis can be worn right over her bandages even before the wound is healed. Indeed, the ingenious and health-minded nurse can seize the opportunity to discuss a properly supporting brassiere with many patients who have never before considered the matter.

Of course this problem differs for each patient and the matter is never quite so simple. Women are not only concerned with what the public thinks, but even more deeply with how their husbands will feel about them in the continuing intimacies of their marriage relationship and how their children will react. It is important to remember that privacy is often sacrificed or non-existent in the small apartment confines of most city dwellers.

A considerable number of these patients are still in the childbearing age. Many have not yet had their families. The advisability of risking pregnancy may become a vital question which should be referred to the doctor. Soon the wound heals and the dressings are discarded. The healthy patient resumes her normal responsibilities and usually feels that she would like to forget the whole matter. The responsibility of the public health nurse to develop in the patient an understanding of the importance of follow-up is a continuous one. She must be aware of the characteristic metastatic pattern of cancer of the breast and the significance of signs in the other breast, complaints of bone pain, of coughing, and of digestive disturbances. If recurrence or a metastatic process is discovered and the patient is premenopausal she is usually placed on a course of x-ray or hormone therapy which produces a menopause with all of its attendant manifestations. Here again the public health nurse can perform a real service to the patient in helping her through this trying period. It is heartening to see how earlier detection and this kind of radical therapy have improved the five-year survival rates.

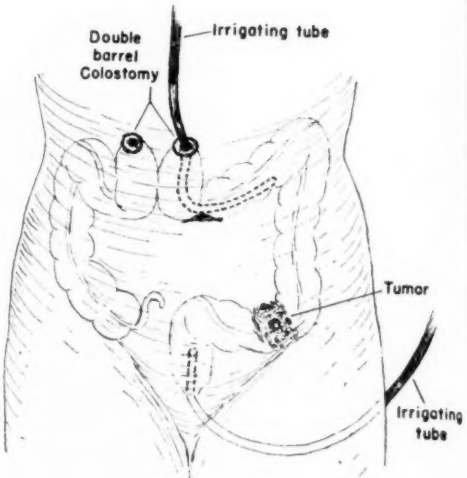
THE EARLY DETECTION of internal cancers is much more difficult. Any of those which occur in the pelvis may involve the recto-sigmoid, either as a primary site or secondarily by infiltration. In any case, it may be necessary to construct a colostomy. The colostomy, because it substitutes for a functioning organ, requires continuous active participation of the patient. Before the public health nurse can help the patient with the plan which has been made for his management, it is important for her to realize that there are several different kinds of colostomies and a variety of theories of how they may be managed. An accurate description of the surgical procedure which has been done and clear and specific directions from the doctor or clinic regarding the plan for postoperative care are essential.

The single-barrel colostomy is formed by bisecting the colon and removing the rectum and sigmoid. The remaining distal end of the colon is pulled through the abdominal wall, forming the colostomy stoma. A double-barrel colostomy is constructed when the loop of bowel is brought up through the abdominal wall and opened, exposing the lumen to the proximal and distal portions. Therefore, one



opening will lead superiorly to the colon and the other inferiorly to the sigmoid and rectum. This type of stoma may be the end result of a palliative operation to relieve obstruction, or it may be the first stage of a variety of two-stage operations. Whatever the plan is will determine the nurse's interpretation to the patient of what he may expect.

In either of the above colostomies the normal bowel movement passes through the opening involuntarily since there is no sphincter present. The main nursing problem, therefore, is to help the patient establish a method of management which will maintain control of these discharges. This can be so successfully achieved that the patient may return to normal activity at home, at work, and in the community at large without fear of social rejection. This control can be achieved by mechanical irrigation of the colon, dietary restriction, or a combination of both.



If secure controls can be achieved by mechanical means it is believed that the patient will make a better postoperative adjustment. The demands of a special diet generate problems around the most social function of all—the activity of eating at the table. It creates shopping and food preparation problems at home. Average restaurant facilities make eating out difficult and expensive whether at work, socially, travelling, or otherwise. The patient comes to believe that he is not a well person and his defect becomes a matter which continually attracts community attention. The discussion of diet should reassure the patient that he may eat as he always has, that his diet should be well balanced and adequate for his needs, that he will have the same idosyncracies he has always had, and that by experience he will choose to avoid those foods which produce diarrhea or flatus.

Control of colostomy excretions starts with daily irrigations on the fifth day after operation. The nurse from the first uses the treatment as a teaching demonstration. By the eighth day the patient has learned to manage his own treatment with little help in the bathroom under conditions which are comparable to his home setup. The patient is taught to irrigate until a clear return is obtained, regardless of the amount of fluid required. If this is done the treatment will be necessary only every second or third day and the patient will have no discharge between irrigations. Wearing a bag is not necessary and is discouraged. A fold of gauze or tissue is the only covering required. The patient is helped to plan his irrigation at whatever time of day it can be done without interruption by other members of the family since one to one and a half hours must be allowed. The Binkley irrigating set has been found to be a satisfactory appliance because it is clean and directs the return flow into the toilet bowl. It is also arranged so that the patient can be free to care for himself without requiring anyone else's assistance.

As the public health nurse helps the patient make his adjustments to the home and develop his competence, her main contribution can be the assurance that as soon as the routine is well established and the intestinal rhythms become habit, the patient may go through his usual daily activities with a calm and secure feeling. He can go to the movies, the ball game, and social gatherings without feeling different from what he was prior to his illness.

Another type of colostomy with which we are becoming more familiar is the wet colostomy. If the tumor is found to involve both the rectum and the bladder both of those organs may be removed. In that case the ureters may be implanted into the colon so that both feces and urine are excreted through the colostomy stoma. In this case, management by irrigation is not feasible because of the continuous urinary output. As a matter of fact, irrigations are contraindicated because of the danger of forcing infected material through the ureters into the kidney. Tub baths and swimming are also contraindicated for the same reason. This type of problem makes it necessary for the patient to wear a special kind of bag. At present the Pierce bag which can be applied over the stoma even before the sutures are removed from the incision is used. The patient learns before discharge from the hospital how to apply and care for the bag. He is also shown how to cut it to fit the stoma as it changes in size. He has worn the bag in the hospital for some time before discharge and will go home wearing the bag he has applied himself.

When the effort to destroy the patient's tumor has failed and uncontrollable recurrence and metastasis are present, the patient must be encouraged to live as actively, productively, and self-sufficiently as he can as long as possible. These tumors may become ulcerated, infected, necrotic, and very bulky. Much of the pain and odor in these cases can be alleviated by good nursing care which reduces the local infection. The patient may be taught how to irrigate his wound with acetic acid solution, Dobell's solution, or peroxide, and how to dress it, if he has the necessary equipment. If the patient is unable to obtain an adequate supply of dressings, arrangements for having them sent to him can be made with the local cancer society. The patient should be encouraged to go to his physician's office or the clinic daily as long as he is ambulant and then to use, if available, transportation services as long as possible. His ulcer is cleaned, debrided, and dressed, and he is encouraged by the fact that something is being done. Dressings saturated in zinc peroxide preparation, which oxidizes slowly over a long period of time, are often applied. As the patient becomes more and more debilitated the problems of adequate nutrition, skin care, and narcosis for pain become of increasing importance. No patient should ever be allowed to feel abandoned or hopeless. Indeed, we are all justified in a sincere hope that even as we comfort and prolong the life of each new person, the secrets of this disease will be unlocked and the remedies discovered.

REFERENCES

Best, Nelliana. Radiotherapy and the nurse. *American Journal of Nursing*, March 1950, v. 50, p. 140-143.

Keller, Caroline. Raising the cancer patient's morale. *American Journal of Nursing*, August 1949, v. 49, p. 508-511.

Macdonald, Eleanor J. Present incidence and survival picture in cancer and the promise of improved prognosis. *Bulletin of the American College of Surgeons*, June 1948, v. 33, p. 75-93.

Cancer among children. *Statistical Bulletin*, Metropolitan Life Insurance Company, January 1949, v. 30, p. 5-8.

Taylor, Grantley W., and Wallace, Richard H. Carcinoma of the breast—end results: Massachusetts General Hospital 1933-1935. *New England Journal of Medicine*, September 25, 1947, v. 237, p. 475-477.

Johnson, Dallas. Tracing the facts about cancer. Public Affairs Pamphlet No. 38, 1947.

The Public Health Nurse in a Cancer Control Project

MARY A. SEARS, R.N.

"FRANKLY, I have always had a fear of cancer, but from your talks I feel I am now better equipped emotionally to help a patient adjust to his problems." This comment from a nurse participating in the local cancer control demonstration program now under way in Maryland is indicative of the gains being scored. One of the three major objectives of the project, which is carried on by the State Department of Health in cooperation with the Maryland Cancer Society and the U. S. Public Health Service, is to demonstrate the potential contribution of the public health nurse to cancer control through a generalized nursing program.

Other objectives are: to establish a pilot cancer reporting and register system for use at the county level and to make an epidemiological study of selected cancer cases. It is hoped that the project in which four Maryland counties—Frederick, Harford, Montgomery, and Washington—are participating, will "demonstrate the effectiveness of certain cancer control technics at the local and state health unit levels which may be applied throughout the nation."

There are some forty public health nurses in the four counties, about one per 7,500 of population. Their role in the project is fivefold: case finding, case holding, follow-up, home care, and education. It has frequently been said that the public health nurse is one of the most effective workers in the field of cancer control.

In the program an attempt has been made to work out procedures for nursing services and to evaluate certain aspects of the nurse's work. A nursing consultant assigned to the demonstration from the National Cancer Institute worked with a statistician, also from the institute, and with state and local personnel, in developing forms and procedures, as well as the educational plan to be followed under the program. Consultations were held at frequent intervals with the chiefs of the State Division of Public Health Nursing and the State Division of Cancer Control.

It is hoped that this experimental work in planning and evaluation will throw light on some of the following questions: Do persons with suspicious symptoms actually go to the physician? Do they continue to visit the physician until adequately diagnosed and treated? Is the nurse effective in helping the physician follow up treated cases? In view of the many activities already assigned to the health department nurse should she be encouraged to give an increased amount of bedside care to cancer patients? Is it possible to measure the extent of her formal and informal cancer education work?

An active register of cancer cases was set up. It was the belief of those who planned the project that nursing services to the cancer patient would be greatly improved if such a register were established and maintained at

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the local level. In fact, the use of this register as a basis for nursing services was believed to be one of its most important functions.

STAFF EDUCATION

About ten hours were devoted to staff education in each county to prepare these nurses for their part in the project. In addition, four hours were spent in discussing the study manual with the nurses, the county health officer, and the study secretary who was to be in charge of the register.

Staff education included consideration of the more common sites of cancer, with emphasis on those with which the nurse will deal most frequently and with which her work will be most effective. Discussion included incidence, symptoms, precancerous conditions, diagnostic and treatment methods now in use, prognosis, complicating social and emotional factors, nursing care in hospital and home, and preventive methods currently known. Excellent teaching materials were available, but, on the other hand, one important teaching method was lacking: the opportunity to observe cancer patients. Although this deficiency was recognized, it was impossible to remedy at the time.

As far as possible, classes were opened to personnel from neighboring counties and to all workers with cancer patients. Thus, 9 counties were reached instead of 4. In addition to 55 health department personnel from the 4 counties, a total of 97 others attended, including industrial, school, hospital, and insurance nurses, nursing home directors, practical nurses, social workers, and staff of a cancer society and a crippled children's league.

A few incidents may illustrate the educational value of the study. One director of a nursing home asked to borrow an article regarding the care and problems of the aged in order to type a copy. "That says just what I have been trying to say to my workers in just the way I have been trying to say it," she explained.

An elderly practical nurse from the county home phoned to ask if she might attend the classes, as cancer patients were among her most difficult nursing problems. Since she was too shy to take part in the discussions, we did not know until we visited her infirmary that a valiant job was being done there by an overworked and self-trained staff.

Material regarding control of pain and odors, and care of pressure sores was requested frequently.

On their own initiative several nurses visited radiology departments and hospitals to learn what facilities were available for diagnosis and treatment. One who visited a large lingerie shop to discuss properly fitting brassieres and breast prostheses reported that the manager of the shop was very eager to learn more about the subject.

A health department nurse said, "On entering a house I find myself observing each individual for symptoms of cancer. If there is a woman of menopausal age, I immediately try to find out whether she is having any of the symptoms discussed in your lectures."

RECORDS AND PROCEDURES

As nursing records and procedures were planned, the guiding principles were to make them an asset, rather than a burden to the nurse. Information should flow over her desk and not have to be dug out of files. Every effort was made to reduce paper work to a minimum so that more time could be spent in work with patients.

The following procedures have been developed: When a physician's report of a cancer case is received, the study secretary transcribes the information to a Cancer Register Card and also to a Request for Nursing Service Form. The latter is routed through the supervising nurse to the staff nurse, who phones or visits the physician to discuss the need for nursing service and to ask whether the diagnosis is known to the patient or to any family member. Teaching emphasis has been placed on the importance of the initial approach to the physician, on the need for a clear working relationship and for proving the value of the nursing service by demonstration.

Information regarding the patient's condition and nursing orders is recorded and re-routed through the supervising nurse to the

study secretary. If nursing care has been requested the secretary prepares a Nursing Service Record, transcribing additional information from hospital and pathologist's reports. Certain items, such as metastatic sites and condition at time of discharge, are included in the hospital report, especially for the nurse's information.

Even if nursing care is considered unnecessary by the physician, information secured from him is recorded on the Cancer Register Card. Thus, if follow-up service is offered at a later date, the nurse will be prepared to discuss the case intelligently.

The Nursing Service Record designed for this study has been well received, as it provides information from reliable sources which helps the nurse give more intelligent care from the time of her first visit. It is designed to help her record visit observations quickly and clearly. Nurses have asked if similar forms could be provided for other health department services.

During the first nine months of the demonstration, 717 nursing visits were made to cancer patients in the four counties. Of these, 46 percent included bedside nursing. It is evident that this number is insufficient for valid statistical analysis of time and costs essential in evaluating a bedside nursing program. However, sufficient data may be available from the nursing records to summarize such factors as kinds of nursing care and instruction given to the patient, and social, emotional, and economic problems recognized and handled by the nurse. Such a summary will help to answer the question, "What is the scope of the cancer nursing problem in a community?"

CASE FINDING AND CASE HOLDING

Several methods of recording activities in case finding and case holding were tried before a satisfactory procedure was evolved. Because of the many steps involved in these activities, it was necessary for the nursing consultant to take the responsibility for collecting the data from such sources as the referral file, family folders, and conferences with the nurses.

An apparently simple referral procedure was found to involve a wide range of activities. When necessary, the nurse guided the referred person in securing financial assistance; arranged and sometimes personally provided transportation to the physician; secured appointments with specialists; gave instructions to patients about these appointments; and sent letters to physicians to secure the diagnosis.

Tabulations for the first six months show 78 nurse referrals of patients with suspicious symptoms. Fairly complete medical and nursing reports are available on the first 64 cases. Of these, 58 visited their physicians, 2 moved away and have not responded to letters, and 4 have not been adequately motivated to visit their physicians.

The resulting diagnoses have included tuberculosis, poliomyelitis, hernia, and psychoneurosis. Two patients have had hysterectomies; 1 an enucleation (phthisis bulbis). There have been surgical removal of 1 nevus, 5 cysts, 2 benign growths, hemorrhoids, and several warts. Treatment has been secured for 1 case of gastric ulcer, 1 of severe pyorrhea, 8 of cervicitis or cervical erosion, and 5 noncancerous lung conditions.

Through nursing efforts, 7 cases of cancer have been found. Two of these, a cancer of the breast and one of the nasopharynx, are now under treatment; 3 skin cancers have been successfully treated; and there are 2 with poor prognosis, a malignant brain tumor and a uterine tumor.

To obtain these results the nurses made more than 220 visits to, or on behalf of, these 64 patients.

PUBLIC EDUCATION

No reliable method was found to evaluate the effectiveness of cancer education work by the health department nurses, because so many different educational forces have been acting simultaneously upon the public. Instead, the cancer education work done by the nurses has been tabulated under three headings:

1. *Prepared talks to groups.* These were not expected to become a major activity. However, in nine months, the nurses have given thirteen speeches before a total of 1,030

individuals at high school, parent-teacher, and similar gatherings.

2. *Talks arranged for.* At the nurse's request, a record is also kept of meetings which the nurse has organized for the purpose of cancer education and for which speakers and movies were provided. In this way, 407 listeners were reached.

3. *Cancer discussions.* The greatest consideration was given to the cancer discussion, which was defined as "a conference or discussion in which the nurse imparts specific information about cancer to any interested persons; or any discussion directed toward the prevention or detection of cancer, which is an integral part of health guidance or instruction in any service (maternity, venereal disease, et cetera) even though the word 'cancer' is not mentioned." The recording of cancer discussions is a new undertaking and apparently will take some time for absorption. Although many cancer discussions have been identified by the consultant in talking with individual nurses, too few are being recorded in the nurses' daily reports to provide valid statistics; still fewer are being recorded in patients' records. Asked whether the item should be dropped from the study, the nurses said, "No, by all means keep it." They said that through this recording of cancer discussions they are becoming much more conscious of teaching points and opportunities. Records for nine months show 617 cancer discussions which have reached 1,089 persons.

The Maryland cancer control demonstration, planned for a period of eighteen months, has reached the halfway mark. When the program is completed we will be able to present more definite conclusions as to procedures through which the nurse can make more valuable her contribution to cancer control.

The Biennial Convention

(Continued from page 376)

ferences are rarely as simple as the polarization of *for* or *against* but usually involve divergences and minor shadings of opinions as well as major deviations. Issues are likely to be associated nowadays with current conditions and situations, about which something can be done. It has frequently happened that issues develop as such only as needs arise which require that decisions be made." Dr. Bixler continued, "Research can aid in clarifying issues. . . . Research is systematic investigation, so planned and conducted as to be complete and orderly in the analysis and interpretation of facts, clear in style of presentation, free from prejudice, and when completed, ending in conclusions which are in harmony with the scope and nature of its stated objectives." Dr. Bixler's paper will appear in the July issue of the *American Journal of Nursing*. The *Journal* will also publish at a later time, Julia Miller's report on "accreditation and classification in nursing." Miss Miller, acting director of the National Nursing Accrediting Service, presented her paper at the NLNE meeting also.

The foregoing roundup of news and highlights gives a good many of the facts of the 1950 Biennial Nursing Convention. It tells little of what makes a convention an exciting, vitalizing event—to be recalled for years to come. In San Francisco there was a strong feeling of togetherness, of belongingness among all groups. There was evidence of emerging leadership among nurses who had previously not been vocal in national meetings. There was an increased indication of interest in citizen activities in health programs—all things which promise well for the future.

In an informal moment, Miss Fillmore said, "Listening is not always the best way of knowing what happened." We hope that reading this report will help you to understand what happened at the nursing convention at the midcentury, and what steps we all have taken to march forward to a brighter nursing future.

HUMAN NEEDS AND NURSING

NORMAN REIDER, M.D.

THE INVESTIGATIONS and reflections presented herein are admittedly only a small part of the vast subject. The particular approach chosen, the psychological and cultural aspects, represents more an attempt at adoption of an attitude towards the study of many problems facing the nursing profession than any conclusive work. The invitation that I received to speak to you asked that I stress the point of view which recognizes that there are basic human needs regardless of culture, and that I consider in my remarks ways in which the nurse with her knowledge of these needs could develop greater understanding and give more valuable nursing service. The title "Human Needs and Nursing" does seem to emphasize the need for nurses to understand basic human needs and, in understanding them, give greater service. There is still another point of view, that is, the recognition that this problem is inextricably bound up with the human needs of nurses themselves. I intend to deal with both aspects.

Historically, the first element to be considered is the recognition of the nature of the patient which led to the creation of nursing as a profession. In the days before the era of schools of nursing, the religious, military, and scientific forces exerted a strong influence on women to nurse the sick. All of these forces held a more or less tacit assumption that it was the woman who understood the needs of the sick person better than the man. Centuries ago, without recourse to the terminology of the scientific psychology, recognition that the sick individual regresses under the impact of an overwhelming illness over which he has no control, led to the axiomatic if not intuitive conclusion that such a regressed individual is best cared for by a woman. The weakness, the pain, the distress, and the helplessness of the sick individual resembles somewhat the natural state of a helpless infant or child. Therefore, it is not accidental that the term "nursing" should have come to be applied to care of the ill. After all, the mother is the first therapist, and it is towards a mother figure that a sick person turns for relief. Consciously a sick person may have forgotten the magical cures effected early in life by the mother's warmth, gentle touch, tender handling, and the magical kiss that made pain disappear. But the body remembers even when the mind does not; when someone is reduced to helplessness by sickness, the tendency is to crave for those things that made him feel better in the past. Now many excellent textbooks in nursing, especially psychiatric nursing, go into extensive detail concerning these needs, their elaboration, and how they can be met from the scientific point of view. There is no longer any doubt that, at least to a certain

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extent, what was done largely on an intuitive basis in the past can now be imparted to others. This field has now become the task of the nursing educator.

II

THIS CONCEPT of the nurse as a sort of scientifically trained mother-substitute somehow does not quite jibe with the observed facts. Once more we can take recourse to history to point out some of the disconcerting complications and contradictions which affected this concept. I wish first to point out the traditional attitude that there is something holy about nursing, as if it were practically a religious calling. Florence Nightingale herself put it in this way, "I do entirely and consistently believe that the religious motive is essential for the highest kind of nurse." From this and other expressed attitudes the tradition of nursing has been infused with an idealized spirituality that somehow or other has not been maintained as universally as might be desired. Attempts are still made to instill in student nurses a feeling of nobility and something of this "priestess" motif. My own observations in these present times lead me to believe that if a nurse does not bring some of these ideals with her when she enters the nursing profession, it is most unlikely that she will attain them during her nursing school years. There are numerous derivatives of the idealized picture of a nurse existing in the older writings, but for the compact picture, I know of no better delineation than that which appears in the delightful article by a West Coast doctor in which he gives his maxims for nurses written forty years ago.

"Remember that, in assuming the vocation of nurses, you have also assumed a responsibility to reflect credit on the profession of your choice, by conducting yourselves at all times with becoming modesty, and while on duty, with unrelaxing dignity and decorum.

"Remember that your first obligation is absolute fidelity to your patient, coupled with unswerving loyalty to your attending physician. Study carefully the letter and spirit of the word loyalty, and practice it unflinchingly toward the hospital and training school with which you have allied yourself and toward those in positions of authority.

"Your patients will lean upon you for moral support and for human comfort while under the stress of pain and sickness, their self-reliance is at its lowest ebb. Learn to be equal to these demands, which you will meet, not by volunteering sympathy, or by protestations of attention, but by the spirit of willing service, and animated by your love of humanity, the close attention to the duties of a nurse.

"Remember that under no circumstances are you to discuss with your patients, other patients, or physicians, matters pertaining to the management of the training school or hospital with which you are connected.

"Efforts to engage you in these discussions by your patients, who intend no harm, will try your courage, but should be met by polite and tactful silence or evasion.

"Failure to observe this rule will destroy your usefulness as nurses and is unforgivable.

"Remember that there is a time and place for all things, and that the hours of duty and that the wards, hall, or other precincts of a hospital, are not those for social converse, or interchange of pleasantries.

"Avoid congregating in groups of three or four, do not indulge in laughter or loud talking.

"Never conceal or pardon an omission of duty on your own part; the intercession of your superior is necessary, to whom you should promptly and frankly report.

"Never permit yourselves to relax in interest or enthusiasm in your work. Form the highest ideals of the beauty and dignity of your calling. Read the best books and exercise your purest imagination.

"Never forget that you have a duty to yourselves. Preserve your minds and bodies by the exercise of rational rules of living; close attention to the hours of duty; thoughtful application in the hours of study; wholesome enjoyment in the hours of recreation; complete relaxation in the hours of rest."[1]

These maxims would undoubtedly appear to a great majority of nurses and doctors as appropriate even today. Let us now inquire as to the implication of such rules for behavior so far as nurses are concerned. I venture the following are the feelings which dwell between the lines. It is implied that the perfect nurse is loyal, virtuous, asexual, solicitous, uncomplaining, and totally absorbed in her work alone. Let us ask further: Why the necessity for all of these maxims, unless it is implied that if left to her own devices, the nurse may be disloyal, spontaneous, interested in men, and not interested in nursing? In other words, what such maxims and the usual rules in schools of nursing betray is the distrust of the human needs of nurses themselves.

What must have happened historically, then, between the time of the origin of nursing as a profession with high ideals, and a time not too long after the beginning of nursing schools, was the recognition that not all women who go into nursing are idealistically motivated, and authoritarian curbs may be necessary to keep them in line. It is my belief that this authoritarian attitude in itself is a single most important factor, in its attempted enforcement of ideals, in lowering the dignity and spiritual elements in the nursing profession. By contrast, the younger profession of social work is at present more attractive, gives and yields more personal satisfaction because the spontaneous spirit is permitted to develop without the authoritarian attitude.

But progress is being made under the impact of more intelligent social and psychological factors; recognition of human needs in nurses themselves is at last coming to the fore. Witness the excellent remarks made two years ago by Dr. William C. Menninger,[2] "Any individual, including any nurse who becomes routinized and rigid, established and complacent, is falling short of her maximum self-realization or her greatest satisfactions. Such a state of affairs only means resignation. Nurses do not have to give up being women and citizens. It is unfortunate if they should give up their dreams and hopes for a home and family. Certainly, inside and outside of hospitals nurses are also citizens and live in communities. Never need any nurse permit herself to become an isolated, one-track spinster, and it is extremely unfortunate if the nursing profession, either because of its present make-up or because of its attitudes, ever permitted such a prospect to be accepted as the expected outlook of the nurse."

III

I have not forgotten that my topic relates to how nurses can best discharge requirements made of them. Nor have I forgotten the intention of relating their own needs to the needs of their profession. But there is still another large field which may give us important clues in this interrelationship. This has to do with an examination of the motives of those who go into nursing. In recent years there have been several studies on the problem of occupational choice.[3] Two excellent studies[4,5] have now been done on the nursing profession itself. What can we learn from these studies?

Before summarizing points from these studies and observations that I have made with the assistance of interested nursing supervisors,[6] I shall make some remarks on the methods of these investigations. Most of my observations come from questionnaire and interview studies. It is very well known that such studies may touch only on superficial factors. Some of these observations have been implemented by a much more detailed study of individual nurses, which serves in the main to substantiate what was found out in more superficial investigations. Enough cogent material, however, is present to indicate that the forces which motivate people to enter the nursing profession are multiple: social, economic, and psychological.

The pitfalls of superficial modes of investigation are numerous. In one study, through the use of the questionnaire method, student nurses were asked about their future plans. When the questions were stated in a certain way, a high percentage of the answers indicated most students intended to stay in nursing. However, in another study when questions about future plans were phrased differently, the results indicated that the great majority of student nurses expected to be married and to have children five years after graduation. This single fact is of tremendous importance to those making plans for programs[7] in the nursing profession for, up to now, it has been neglected. Is it worth the time and the money involved to train nurses for a highly skilled profession when the majority of them anticipate that it will be only a temporary endeavor? There are some who would probably be quite alarmed by this and would wish to make revisions in programs to secure some degree of assurance that women trained in the profession would stay in it. I for one am not particularly disturbed by this discovery, which incidentally, has been known to nurses themselves for decades, but which has been treated as a sort of secret

among ladies. Let us go on. What additional facts do these studies reveal which shed further light on the problem?

A RELATIVELY small percentage of nurses, a group in itself quite interesting psychologically, consists of those who have wanted to become nurses ever since the ages of four to six. Some had the choice of the profession foisted upon them by their mothers who had been frustrated in their hopes of becoming nurses themselves. Some were patients in hospitals in their early years and thereby were attracted to the profession because of a memory of kind treatment. The great majority of nurses seem largely to have been motivated in their adolescence.

"A career of nursing is often chosen during high school years or earlier. It appears that girls who enter nursing do not, as a rule, drift into the profession without giving much thought to their choice. In studies of the vocational preferences of high school girls, nursing is found to be one of the vocations most often mentioned. . . ."[8]

This quotation represents fairly accurately the superficial attitude, but what has gone on in the crystallization of this attitude? We find the following composite picture: the high school girl would like to get away from home and be independent. She is only mildly motivated by altruistic and humanitarian motives. Occasionally a tinge of religious drive is present. She looks for a vocation with a certain amount of prestige value with economic safeguards. She would like to get married and have children, but is a little uncertain about how her marriage might work out and would like to have a good profession to fall back on in case it doesn't or in case she never gets married. In some instances she would like to go to medical school but sees this as an economic impossibility and therefore chooses nursing as a substitute. Another psychological motive is present in some cases in which there is an expressed interest in the scientific aspects of nursing as a preparation for marriage, a sort of attempt at belated mastery of anxieties concerning bodily function. Anticipations of the nursing life are further muddled by the glamour of the uniform, fantasies of the role that may be played in the drama of life and death, fantasies of meeting and marrying a wealthy doctor or patient, and some vague hope that the training program will take care of personal deficiencies in relationships to people. Radio programs, magazine articles, and advertising copy for Kotex, penicillin, and sacroiliac belts concretize the confused vagueness of what is to be anticipated.

As to deeper psychological motives, it is most difficult to generalize because of paucity of material. In the relatively few cases where I had an opportunity of studying deeper motives, the following factors were important: (1) strong identifications with mother figures; (2) strong reaction-formations which usually afford adequate means of denial of feelings of hostilities toward people; (3) an acting out of a fantasy of being very important to people and thereby obtaining love and in turn by ministering to the sick giving evidence of love. In some a strong masochistic trend is present. For these, work constantly serves as a punishment for forbidden wishes. But I do not make too much of these isolated instances because it is an open question how universal these factors are.

IV

What happens to our young women who go into schools of nursing? First, it is amazing to realize that 27 to 39 percent of students[9] withdraw from school prior to graduation. The total number of students so involved, I would venture to guess, is higher than in any other professional group. It actually amounts to thousands each year—a great loss the nursing profession can ill afford. When one examines the reasons for withdrawal, one finds the reason given for the highest percentage of withdrawal, "failure in class work." I have not had the opportunity of examining any extensive list of individuals who have so withdrawn, and from my limited experience I know that this "failure in class work" covers a multitude of other reasons which are definitely not scholastic. They are almost entirely due to difficulties in interpersonal relations in which the immaturity of the student nurse herself is but one factor. From my observations these factors are largely due to

the continuation of the autocratic attitude toward a student nurse and failure to meet her own needs. Tremendous progress has been made in nursing education, but it has been pointed out that in spite of the progress in the direction of democratic principles of education, the prevailing atmosphere is still an autocratic one. I suppose in all fields of professional apprenticeship and training, the authoritarian setup is unavoidable. But there is still too much disbelief in the student nurse's ability to take care of herself, imposition of unreasonable restrictions and discipline, and demands of an unprofessional nature. It therefore takes a high degree of motivation and/or a high degree of masochistic absorption to withstand the indignities to which many students are subjected. These indignities come from three directions: (1) from immediate superiors who seem to take out on the student nurse what was once taken out on them (2) from doctors who so frequently consider the student nurse as a mechanical instrument to carry out their wishes and not as a partner in a common endeavor (3) from the public, which seems to be increasingly concerned with the question of whether it is getting its money's worth and is unappreciative of what is being done. In this latter connection I should like to digress to a particularly interesting paradox which exists in our present-day culture, namely, that to an appreciable segment of our population the nurse is regarded as sexually loose and of easy virtue, whereas actually as a group, nurses are quite prudish, moralistic and inhibited. It is quite beside the theme of this paper to go into this cultural and psychological phenomenon.

Why are all these points raised? Do they have any bearing upon the general topic under discussion? I believe they have. One summary of the studies that have been made can be phrased in the following way. Unless a nurse is unusually and highly motivated out of religious or altruistic reasons (often quite unrealistically) or unless her particular neurotic personality factors suit her to her work, or unless she is socially and economically trapped, the training period of a student nurse does not permit much realistic satisfaction. The importance of all this is predicated upon what seems to be a valid assumption: that unless the nurse's human needs are met in her work, she will be unable to satisfy the human needs of her patients

V

It is not merely an assumption that a happy nurse is a good one, that one who is able to attain satisfactions in her work and in her outside life is an effective nurse, and that the dissatisfied nurse takes it out either on her patients or on herself. There is a considerable amount of evidence to support this contention. What concerns us here is the pathogenic role that the autocratic system in nursing education and nursing administration plays. The dynamics involved are relatively simple. There are instances of failures in women in nursing which are not at all due to our nursing education system. Some young women bring to the school immature, unrealistic, and neurotic attitudes which the curriculum cannot possibly set straight or correct. However, in these and even in relatively normal young women, an autocratic attitude with its repressive over-restrictions and over-disciplinary measures, brings about regressive changes which threaten their psychic equilibrium. Unresolved parental conflicts are, as a result, frequently intensified. Most significant in my observations of nurses is that there is no healthy outlet or sublimation for the hostilities engendered from the frustrations they suffer; the net result is the taking out of hostilities chiefly on themselves. This I believe is one of the chief psychological factors responsible for the major complaint of nurses, chronic fatigue, which operates in conjunction with real external factors which undoubtedly exist.

The significance of this point is also a simple one. One cannot expect individuals whose mode of life is on a regressive level because of an imposed regime to treat adequately patients who are also functioning on a regressive level because of illness. (In a way this statement then is not entirely correct, because it has been done and it is being done after a fashion through direct and indirect intimidation and the subtleties of superior

office, but our concern here is not the training of automatons but the gratification of human needs in human ways.) By and large a nurse in a state of conflict because of her inability to obtain sufficient affection from others will find it very difficult to give any to patients. A nurse inhibiting her hostile tendencies will occasionally take them out on the patient. Examples of this sort can be multiplied a thousandfold. What one sees is that the nurse after years of battling with her problems develops a chronic syndrome of fatigue, indifference, and partly controlled bitterness.

The excellent recommendations of the Committee on the Functioning of Nursing[7] give evidence of the recognition of these defects. All I have attempted to do herein is to give substantiation to the aim of the program advanced by the committee through some investigation of the psychological factors involved. To combat regressive possibilities and to facilitate the development of student nurses toward maturity, some measures are clearly indicated from the psychological point of view: (1) the presence of strong, respected, and understanding leaders, so that a nurse may have the opportunity for healthy identifications (2) a cohesive and cooperative group life to give those members of the group who need it most strength from the group itself (3) more democratic attitudes (4) the lessening of restrictions in the pursuit of real satisfactions as well as sublimations. In this latter connection I should like to mention that it has been called to my attention that marriage of student nurses is not opposed in some schools of nursing. Where these restrictions have been lifted there has been no regret on the part of the administrators. A happier nurse is a better nurse. Apparently once more in another field the idea that sexual repression is necessary to the attainment of satisfactory educational goals is not substantiated.

The task is not an easy one, especially since whatever is attempted in these directions can be very easily nullified by external changes, social, economic, and political, in this country. But despite these factors over which the nursing profession has no control, it must with the help of the allied professions, strive in the direction of making the nurse a happier person. A little less masochistic sacrifice and a little more personal satisfaction is a good slogan.

REFERENCES

[1] Cutter, James Bird. A west coast doctor reminisces. *American Journal of Nursing*, April 1950. v. 50, p. 212-214.

[2] Menninger, William C. Opportunities in nursing for a satisfying life. *American Journal of Nursing*, August 1948, v. 48, p. 525-529.

[3] Ginzberg, E., and others. The problem of occupational choice. *American Journal of Orthopsychiatry*, January 1950, v. 20, p. 166-201.

[4] Nahm, Helen. *An evaluation of selected schools of nursing with respect to certain educational objectives.* Stanford, California, Stanford University Press, 1948.

[5] Ingmire, A. E. Attitudes of student nurses at the University of California. Doctorate dissertation.

[6] Personal communications: Corinne Parsons and Frances R. Milono. Langley Porter Clinic, San Francisco.

[7] Committee on the Functioning of Nursing. *A program for the nursing profession.* N. Y., Macmillan, 1949.

[8] Cunningham, Bess Virginia. *Psychology for nurses.* N. Y., Appleton-Century, 1946.

[9] American Nurses' Association. 1948 facts about nursing. 1949.

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CAN IT BE FORTY YEARS?

ETELKA W. YOUNG, R.N.

YES, FORTY YEARS ago on the seventeenth day of February I left off my pretty blue checkered uniform, fichu, and apron, put on the white uniform I wore for graduation, and assumed my duties as acting assistant directress of nurses. Forthwith, I also became the teacher of anatomy and physiology, subjects which I had learned from a book written by Miss Diana Kimber and from——, but maybe she does not want to be identified with teaching anatomy and so forth more than forty years ago.

When the new directress was due to arrive, and the real assistant ready to reassume her own job, I was recommended and accepted for the position of superintendent of a small and busy hospital in a neighboring state. There was also a training school for nurses. I valiantly carried all these new responsibilities, with spells of cleaning, remodeling, reorganizing, and trying to get the Legislature to subsidize the institution. We had a wonderful board of trustees and a board of directors and much later, after the Legislature responded, even a resident physician.

We had completed formation of a county nurses' organization of which I became the first secretary, but more and more I questioned what I was doing. More and more I felt handicapped by my youth and limited knowledge and experience. I wondered what happened to the poor patients who were "cured," but were certainly not well enough to resume their tasks when they left the hospital. Why did the seven-year-old girl whom we sent home after she recovered from a severe attack of typhoid fever die less than a year later as the result of another preventable illness? I began to feel very strongly that I was "my brother's keeper," but I did not know how to go about "keeping" him. I had heard rather vaguely of "settlement work" and "visiting nurses," and made up my mind to find out more about such things.

I was fortunate in being referred to Miss Julia Stimson, then head worker in the Social Service Department of the Washington University Hospital in St. Louis. Miss Stimson listened to me with attention and with understanding; when I got through with my story she asked me if I were interested in a fellowship at the School of Social Economy affiliated with Washington University! Wasn't I lucky? Miss Stimson sent me to see Dr. George B. Mangold, director of the school, and in a short time I was the dazed possessor of a fellowship which paid thirty-five dollars a month, a part-time job as prenatal nurse which paid forty dollars a month, and an opportunity which was priceless, and for which I shall ever be grateful.

It was through Miss Stimson that I came to know Miss Crandall and the NOPHN. After graduating and receiving my diploma in social work, I remained with the social service department of the Washington University Hospital (now Barnes Hospital) as full-time prenatal nurse until January 1914. Miss Stimson encouraged me to speak in public as much as possible. She took me to many meetings. One day she told me she had recommended me to Miss Crandall as ready to go out on my own. At that time nurses with any type of special training in the social service field were few, and there was a need for them to pioneer in establishing public health nursing services under various auspices and names.

Ella Phillips Crandall was general director of the NOPHN in those days. What an understanding person she was! When I first met

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her she dressed and combed her hair most simply—almost severely. Some years later when I met her for luncheon I was quite surprised to find her a stylish-looking woman with neat makeup and a pretty hat and veil. She looked wonderful and it was wonderful to see her. We talked about old times—Johnstown, the first place she sent me, Flushing, then school again; Baltimore, Denver, Phoenix, Ambler, then South America—all the places I served under the keen eyes of the NOPHN.

I remember also Miss Frances V. Brink of the NOPHN field staff who visited us in Arizona when public health nursing was very new. When I returned from South America Miss Anna Tittman had replaced Miss Brink and, I think, Miss Anne Stevens had replaced Miss Crandall. I cannot recall all the details.

The First World War and the influenza epidemic still stand out as a nightmare in my memory, although somewhat dulled by now. Along with other nurses who volunteered and were eligible, but could not be sent to Europe, I wore a special Red Cross badge and remained at my job. I did volunteer work as an emergency nurse at the Red Cross canteen in the Baltimore Union Station when my regular day's work was over. After about three or four months of this I had to give up for awhile and I wrote to Miss Crandall about it. Her reply fully demonstrated her feeling of kinship toward all nurses.

At that time the vocational service of the NOPHN was on a purely volunteer basis. It was the job of the vocational secretary to fit the right nurse to the right job and bring the two together. So one winter day when I received a wire from the National Organization asking if I should like to go to Phoenix, having expressed a desire for a job in a warm climate, I accepted with alacrity. When the blizzard was over and the trains running again I boarded one of them on a bright, comparatively warm day. It was only four below zero. About three days later, having gradually shed layers of clothing, I arrived in Phoenix in a temperature of over 110 in the shade. I spent nearly three of the happiest working years of my life there.

Since this is not an autobiography but is meant as a tribute to the memory of Ella Phillips Crandall, Julia C. Stimson, and to the fine men and women whom I had the great privilege to know, I shall not go into detail about my jobs. To me they were thrilling and wonderful.

After Phoenix I went to Ambler. I had been there a little over a year and a half when after careful thought and earnest conferences with my board of directors I accepted a position in South America, having been advised to do so by the NOPHN. I had gone to the headquarters at 370 Seventh Avenue in New York for interviews and selected my own successor with the aid of the vocational secretary. Believe it or not, none of this cost me or my organization anything; there was no charge for service. Apparently the NOPHN existed solely to be of service. How they could do this placement work for so long and for only a simple membership fee is more than I can see. As a matter of fact, according to the records I did not become a member until about three months after they got me my first public health job. If there is an organization in the world which is truly for the people and by the people, it is the NOPHN. This was certainly true then, and although I no longer can take an active part in it I think it must be so now.

The last time I saw Miss Crandall was in the spring of 1938 when I was thinking of reentering the nursing field after an absence of about ten years, during which I did only occasional volunteer work. She was ready with her cautious and courteous advice. I am now looking at a letter from her dated October 10, 1938, written from her office at One Madison Avenue. She was sending me her good wishes and her approval at my going to college. "Times have changed nursing education requirements," she wrote, and I am glad she knew that I accepted this fact.

The last time I saw Miss Stimson was at the 1942 Biennial in Chicago where I voted for her reelection as ANA president. Tall, capable, and earnest, she did not consider my four feet eleven inches a handicap. I believe in the life everlasting, and some time, in some nice place I hope to see Ella Phillips Crandall and Julia Stimson again.

Diagnosis Tuberculosis!

MARJORIE MINA LEVY, R.N.

The nurse helps the patient face tuberculosis.

THE SPECTACULAR advances in physical medicine since the beginning of this century have directed so much attention to the body of the patient that we have only recently begun to rediscover and emphasize what was recognized and practiced by the ancients, that the mind and the body are not separate from each other and cannot be treated apart from each other. The great successes of scientific medicine in achieving a more rational understanding of germs and drugs and hence a more satisfactory control of disease, have made it possible for us now to turn back to the person with the disease.

We may even have turned back a bit too far, so that now we talk rather self-consciously about the mental hygiene aspects of a disease. The great promise of, and the urgent need for, mental hygiene is so well publicized and so widely recognized that in our enthusiasm we may over-correct and concentrate on the "mind" as if it were apart from the body. We must try to steer a middle course, recognizing that the physical and emotional needs of the patient cannot be separated. It is the physician and the nurse who are in the best position to understand and act upon this concept.

I want to discuss the relationship between the patient and the nurse at the time the patient receives his diagnosis of tuberculosis and before he goes into the sanatorium. Usually the nurse's first interview with the patient is just after the doctor has given the diagnosis of tuberculosis. The doctor may have shown the patient the x-ray and explained the disease to him, but it is the nurse who sees the patient after the diagnosis and gets the impact of the patient's emotional reaction.

Anyone when told he has tuberculosis experiences an emotional shock; the whole structure of his life is threatened. This emotion must be outwardly expressed or internally struggled with until some sense of comfort is achieved. The nurse may observe as many different reactions to the diagnosis of tuberculosis as there are persons so diagnosed, for the patient will react emotionally according to his basic personality structure. There may be tears, hysteria, stoicism, anger, resentment, or just apathy. Whatever the reaction, it is the mechanism the patient has found useful in easing his own discomforts and fears, and the nurse should learn to handle these emotional expressions therapeutically.

Most nurses have learned to handle tears and grief. But anger or resentment on the part of the patient may be felt by the nurse as a threat and she is apt to respond with some hostility, either directly or indirectly. For example, she may consider him uncooperative. A nurse has to have a fairly good sense of security to be able to take an emotional tirade from the patient and remain understanding and accepting. Yet anger from the patient is a healthy reaction. With

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the proper handling it may be harnessed and channelized into a positive aggression which may help him recover much more quickly than will the depressed and grief-stricken person.

Grief and anger are two of the outwardly expressed emotions. Let us look at the patient who must struggle internally with his feelings, as the apparently stoic person or the apathetic person who seems to show no feeling at all. In recording her visit to such a patient an undiscerning nurse might write: "patient fully accepts his diagnosis and is quite cooperative." It is true that these people appear to be placid and ready to learn the necessary health facts concerning tuberculosis, but they may be just as frightened, insecure, and filled with turmoil as those who show their feelings more overtly. If the nurse will try to identify with the patient at this point, she may be able to get some glimmering of what the diagnosis means to him. To him it may mean separation from family and friends, postponement or possible abandonment of education or vocational plans, uncertainty about the future, a shattering of his cherished life goals. This intense emotional state is no more conducive to learning than a hard blow on the head.

AT THIS STAGE of her relationship with the patient the nurse should concentrate on understanding and accepting him as he is, easing his anxiety, comforting his fears, and offering him the new life goal of recovery. She will be fulfilling a more essential part of nursing than she would be by starting too early to instruct him in the technicalities of tuberculosis hygiene. This initial approach to the human being who is faced with a long-term illness can greatly influence his attitudes toward the future course of treatment.

Nurses have so much knowledge they want to give to the public that they often take an aggressive teaching role, whereas a more subtle approach may be more effective. In her early interviews the nurse can best serve the patient's needs by being a good listener. She should be interested in finding out what the diagnosis of tuberculosis means to him. The patient is often too frightened or shocked or ignorant of what it is all about to ask the doctor for any clarification—like a mother I talked with last week. She had taken her child to a city hospital for a psychological examination because the girl was eight and still wetting the bed. The psychologist, interpreting the tests to the mother, said the child was emotionally disturbed. The mother repeated this to me as though now that she had a name for it the problem was solved.

I asked her, "What does emotionally disturbed mean to you?"

She replied, "Oh it means that she is crazy —we can't do anything with her."

Because of the possibility of so many misconceptions, it is just as important for us to find out the patient's intellectual grasp of words used by the doctor as it is for us to understand his emotional reactions. In fact, knowing what impressions he has about tuberculosis will help us to work with him. Some patients may think that the diagnosis of tuberculosis is a death sentence. They may have known someone who went to the hospital and didn't come back. Another patient may say to himself: "Just one little cavity . . . I have a light touch of it . . . I can soon take care of that by an extra quart of milk and an hour more of sleep."

These preconceived ideas about tuberculosis may be the key to part of the patient's emotional reaction. The nurse may begin to help the patient by discussing these ideas. However, this needs skillful exploration; that is, gently drawing the patient out. The nurse can develop this art, but only by a self-conscious keen awareness of what is going on between herself and the patient. A nurse may, in her eagerness to correct an easily-voiced misconception held by the patient, make some inadvertent remark which would cause him to withdraw his confidence. Consequently, she may never learn of his more deeply rooted superstitions or his unrealistic ideas concerning tuberculosis.

THERE IS NO FORMULA for this art of drawing the patient out. A nurse has to feel her way and gain skill by practice. For instance, a patient may say, "I can't go to the hospital. I know I just couldn't stand it

lying in bed all that time." If the nurse replies, "Oh, I think you can, lots of people do it, you'll soon get over that feeling," she shows she has not accepted the patient's feelings. She has not given him any assurance but has rather increased his resistance. She has not found out anything about the patient except that he doesn't relish the idea of lying in bed a long time.

It is harder to suggest the right reply to a statement like that, for the interview is a relationship between two people, and the nurse's personality must be taken into account as well as the patient's. However, to reply, "Why do you feel that way?" would convey to the patient the feeling that the interviewer accepted his resistance and was interested in knowing more about him as a person. He might then tell many things about himself and his feelings, which would be important to know. This information should be incorporated into his record and passed on to others who will be caring for him at home and in the hospital.

One patient I know resisted the idea of long bed rest in what seemed to be an irrational manner. After a good relationship had been established between him and the nurse, he was able to tell her that he was very disturbed because of a conflict involving sexual perversion and that he relieved his tension with periodic drunks. This patient needed psychiatric help and only with it was he able to accept the prescribed treatment and make a good recovery.

As the mind cannot be separated from the body, neither can the patient be considered as an isolated human being living in a vacuum. He is a part of his social environment and that environment has become a part of him. He is a member of a family, of a group, of a community. His illness will affect them, and their attitudes are all-important for his well-being. In the nurse's approach to the family, again there is no formula. She will need the same basic attitudes that were successful with the patient—the warm sympathetic acceptance of the initial trauma and an attempt to understand what the diagnosis means to them emotionally, intellectually, and economically. She should give them encouragement, and motivate them to strive for a new goal—the patient's recovery.

The nurse's role before the patient enters the hospital is of vital importance. This period determines whether he will regard her—and consequently all other nurses—as a policeman, tracking him down and threatening his right to self-determination, or whether he will think of her as an understanding, friendly collaborator in his recovery and rehabilitation.

This paper is based on a talk given at the Metropolitan Tuberculosis Conference in Washington, D. C.

1950 Procedures for Recruitment of Nurses for Poliomyelitis

Last year brought the highest incidence of infantile paralysis ever reported in the United States. Although it is hoped that there will be a decrease this year, there are more cases reported to date than at the same time last year. There is urgent need for concerted planning in each community for the evaluation and utilization of facilities and personnel to care for the poliomyelitis patient.

"Procedures for Recruitment of Nurses for Poliomyelitis" in 1950 have been formulated by the American Red Cross and the National Foundation for Infantile Paralysis. Organization and functions of the Polio Nursing Committee are outlined as well as personnel policies for recruitment of nurses when needs for nursing services cannot be met locally.

Copies of the procedures for nurse recruitment are available to directors of nursing schools and of nursing services from the American National Red Cross, Washington, D. C.

The procedures for recruitment of physical therapists for infantile paralysis are given in the April 1950 issue of *The Physical Therapy Review.*

The Tuberculous Patient at Home

What the public health nurse can do for the unhospitalized patient with tuberculosis and for those patients who are discharged early from the hospital.

KAREN E. MUNCH, R.N.

THE CARE OF THE unhospitalized patient presents one of the most perplexing problems to the public health nurse because she is dealing with a communicable disease that is easily spread from one person to another and because the best interests of the patient are served if treatment during the active stage of the disease can be provided in a hospital.

A situation of this type is well illustrated in the following case, that of the N. family: This was an average middle class family, consisting of the mother, thirty-one years of age, the father, thirty-five, a radio mechanic, and two children, two and six years of age. They were intelligent, had managed their finances well, and lived comfortably in a four-room apartment.

There had been no serious illness in the group until Mrs. N. developed a severe cold that persisted despite the usual home medications. Only when the cold failed to clear and when the mother began to lose her appetite, lost some weight, and fatigued easily, did she consult her physician. Fortunately the doctor suspected a possible chest condition and arranged for a chest x-ray to be done. The diagnosis of pulmonary tuberculosis was soon made.

Thereupon the private physician explained carefully to the patient the seriousness of her disease and what should be done about it. He also told her that he would ask a public health nurse to visit and give further instructions.

The case was duly reported to the Department of Health. In New York City each newly reported case is required to be visited by a public health nurse. Before making the visit the nurse telephoned the private physician to determine what he had told the patient and what, if any, instructions he wished her to follow. The physician advised that treatment be started at home because of the long waiting period for hospitalization, and asked the nurse to assist in planning this.

At the nurse's first visit the patient was found lying on a day bed in the living room, with the children playing about on the floor. The husband had had to stay home from work to help care for his family. As would be expected, both parents were stunned and bewildered. How long would this illness last? Who would care for the children so the father could return to his job? Would the mother have to go to a hospital? And a host of other perplexing problems that come to every family faced with the specter of tuberculosis. The public health nurse, having a good understanding of tuberculosis nursing and of a patient's reaction to the disease, as well as a personality that enabled her to help both patient and family see their part in a recovery program, was able to allay their fears, reassuring them both, as she answered their questions and

helped them to plan for the care of the patient and children. On inquiry it was learned that the patient's mother lived nearby. The nurse thereupon suggested that she be asked to take over the household duties, thus permitting the father to return to work. She also advised that the grandmother have an immediate x-ray of the chest to rule out any possibility that she had been the original source of infection.

The next important step was to put the patient to bed and start the treatment recommended by the physician. The mother was moved into one of the bedrooms, a small but bright and cheerful room with two windows. This was much more conducive to rest than the living room, and the nurse proceeded to make her as comfortable as possible. Because of the age of the children and the impossibility of keeping them out of the room, the nurse suggested a gate be placed at the door, not only to protect the children from infection but to enble the mother to have a degree of rest, at the same time permitting her to see the children and know what was going on in the household.

The nurse visited the home daily at first, giving nursing care to the patient and instruction in isolation technics. The grandmother, whose x-ray report was negative, had now taken over the household management and was learning to care for the patient. She was taught to give nursing care and shown how to make the patient comfortable in bed by propping her up on pillows, especially at mealtime, or now and then to see the children, or watch some of the street activities.

MRS. N. BEGAN to think about ways of protecting her family and was most appreciative of the nurse's demonstration of how to cover her mouth and nose with paper tissues when coughing or sneezing, as well as of the use of the paper bag pinned to her bed for disposal of the tissues. In discussing the diet stress was put on the need for well balanced meals for all the family and additional citrus fruits, milk, and eggs for Mrs. N. Suggestions were given for serving the meals attractively.

At each visit the nurse reviewed her previous instructions with the family, answering any questions they had before proceeding with new information. The doctor decided to try the patient on streptomycin, this to be given by the nurse. After each injection, before leaving the home the nurse reviewed the symptoms of any untoward reaction and reminded the family to report this to the physician immediately, should it occur.

Now that conditions in the household were more settled and the family reassured, it was time to plan for examination of the other contacts in the family. This was discussed with the father, who readily agreed to arrange for his own and the children's examinations, all of which luckily were negative.

To decrease some of the work of the grandmother and to give the mother more chance for rest, the nurse with the approval of the family, made arrangements for six-year-old Robert to have his lunch in school. At the same time, two-year-old Peter was enrolled in the nearby nursery school which also gave him a chance for group participation. Later, a housekeeper was obtained who came in one day a week to relieve. She, by the way, was made aware of the diagnosis of the patient and taught how to protect herself, and was x-rayed at intervals along with the family.

Everything did not go so smoothly as it sounds; there were many ups and downs. Mrs. N. at times was resentful of being kept in bed, of imposing on her family, and of being bored, besides having sore spots from the streptomycin injections. However, the nurse's knowledge and understanding of the family as a whole enabled her to recognize the patient's emotional disturbances at an early stage and report these to the physician. Her prompt discovery and reporting of this may well have been the reason for the patient's willingness to continue the injections and bed care, which otherwise might have ended at this point. The doctor was most understanding in his encouragement of the patient, as both he and the nurse realized that it is not easy to be the only sick person in an atmosphere of well people.

As the months passed and Mrs. N.'s condition improved, she was gradually permitted to sit up, first one hour, then two hours a day. As she progressed, other activities, such as

planning the family meals, dictating shopping lists, and doing some of the family mending, were added. Later, with the help of the nurse, she prepared the family budget. With each new activity she became more cheerful and her condition improved much more rapidly as she again became a useful and needed person in her household. Now, after a year's period of time, her infection is controlled and she has assumed more of the household duties. Each new activity, however, is carefully planned to avoid needless motions and overfatigue.

It is no longer necessary for the public health nurse to visit frequently, but she intends to continue her supervision until the patient is fully restored to health. Even then she will visit occasionally to counsel Mrs. N. so that she won't take on too much for her strength. At present this family with the help of the physician and nurse have learned to live with their tuberculosis.

SITUATIONS MET by the public health nurse are not always solved so satisfactorily as in this family. Hospitalization is always desirable, but in the case of emergency, care can be provided in the home. Many families can be made to understand the seriousness of the disease, and their cooperation can be secured for the long period of convalescence if given helpful guidance and encouragement by an understanding physician and nurse. However, people in the older age group, who have grown to be a part of their surroundings and feel that any separation from home means a living death, are much more difficult to cope with.

Such a situation came to our attention a while ago. This was a 61-year-old man, receiving public assistance, who lived alone in a very small apartment. His tuberculosis was of long standing and beyond hope of any cure. His condition was growing progressively worse but because of his pride and independence he refused to accept hospital care. Whenever one of the clinic physicians became too insistent on this, he would stay away from the clinic and for many weeks refuse even to open the door to the public health nurse. As he had practically no contact with other individuals and was very neat and careful about his personal hygiene, it was felt best not to press for hospitalization. The nurse visited at intervals, however, just to make sure that he was not becoming a hazard to others and to be at hand to assist him in getting into a hospital should an emergency arise. This finally happened and hospitalization was secured. Realizing, however, that his public assistance allowance would be discontinued and having great difficulty in adjusting to the routines of the institution, he simply walked out of the hospital five days later and returned home. Nothing would make him go back to the hospital. He was determined to live his life amongst his belongings and if need be, to die there too. While he was in the hospital, however, it was found that he had a sister. This information had long been sought by the nurse, but refused by the patient, and was now put to use at once. The nurse called upon the sister who lived nearby, and even though she had not seen her brother for many years, she was prevailed upon to bring hot food to him daily, as the only solution now seemed to be to plan for terminal care at home.

The public health nurse therefore made plans to visit and give bedside care, the sister promised to stop in a couple of times a day, and a doctor was provided through the Department of Public Assistance. The patient's condition rapidly became weaker and he died within a very short time, but in his own home among the things that had meant so much to him.

Some will ask, should not this patient have been made to accept hospitalization, but others will ask the opposite question, should he not have had the right to die in his own home as he wanted to, as he was not a menace to others.

The Discharged Hospital Patient

You may be interested also in another type of home supervision which is being tried in the city of New York at the present time by one of the city tuberculosis institutions and the Department of Health. In this plan patients are discharged from the hospital earlier than would normally be the case, some even

with sputum still positive. They are obviously in need of close medical and nursing care but, by their discharge, make available beds for others who are more acutely ill.

Patients in this program are selected with considerable care, as are the homes to which they return. Supervision and care of this patient do not differ from what has been described previously, though considerable effort on the part of the public health nurse is required, if the plan is to be successful.

Attention must be given to the physical make-up of the home. Facilities must be available for proper isolation of the patient as well as for safeguarding the other members of the family. Both patient and family must be understanding of the nature of the problem and show their willingness to cooperate in such a program. In other words, the nurse must be sure that the patient can have suitable surroundings and such other assistance as will maintain the benefits that he has gained in the hospital and continue his improvement in this home environment.

ONLY WHEN THE above conditions are met and both patient and family prepared, does the discharge take place. The public health nurse continues to help them adjust to each other, and to see that the medical recommendations are followed. The frequency of the nurse's visits depends upon individual needs of each family and ranges from health supervision and education to bedside care; the nurse must be always alert to any symptoms or lapses that might be disastrous to the patient.

This program is new and has not yet had a fair and complete trial. But out of the seventy-five or more under this type of care at present, only six patients have had to return to the hospital.

I have briefly reviewed what the public health nurse can do for the unhospitalized patient and the patient on home care. In each instance the nurse assists the individual to gain better understanding of his illness, to assume responsibilities for his own recovery, and to prevent further spread of infection. Her professional skill and training as a nurse do not accomplish it all, but in correlating her efforts with those of other experts in the fields of medicine, nutrition, social work, rehabilitation, and mental hygiene, every opportunity is provided to restore families to the fullest physical, social, vocational, and economic usefulness of which they are capable as citizens in the community.

Miss Munch is district supervising public health nurse, New York City Department of Health. This paper was given at the panel discussion, "What Can We Do for the Unhospitalized Patient," during the annual meeting of the National Tuberculosis Association in Washington, D. C., in April 1950.

Commentary on the Unhospitalized Tuberculosis Patient

ALTHOUGH MISS MUNCH'S discussion of the care of unhospitalized patients was written with another purpose in mind it does have some excellent illustrations of and implications for consideration of the uses of what may be considered good mental hygiene concepts in nursing.

"Rest" is one of the fundamental rules for the cure of tuberculosis. Provision of an environment which provides maximum rest is an important part of good nursing care. This usually is thought of as putting a patient to bed and "encouraging" him to stay there. But there is more to it, as this discussion implies.

In the first situation Miss Munch describes there are many aspects of this which may seem obvious but which I should like to discuss as an example, an interpretation, of what mental health nurses see as "mental hygiene aspects of nursing care."

Reassurance, meaning relief from anxieties, is certainly a part of the care given to this family. We are told *some* of the things the nurse did. Some are left to speculation. First, she consulted with the patient's private physician before making her first visit. This en-

abled her to reinforce his recommendations with the kind of authority which removes doubts, promotes confidence, and reduces strain. That is "restful."

In her first visit to the home of the family she found "as would be expected, both parents were stunned and bewildered." Then, because she was medically and socially well informed, she was able to answer their questions. People often are stunned and bewildered because of an unexpected and serious diagnosis which calls for complete readjustment of all their plans for living. In such circumstances it is usual to find them unable to formulate such pertinent questions as these parents did. We are not told what enabled them to do so at this point. Perhaps they possess the kind of personal resiliency that makes it possible for them to meet serious crises without too much disorganization. More probably the nurse helped them through her knowledge and understanding.

I say "more probably" because it is implied in the account that she *listened* to them before she *participated* in their planning. Both these activities tend to reassure, therefore to aid in putting to rest. Active listening helps by making people feel that an authoritative person understands. At the same time it provides the nurse with knowledge of the details of the situation as well as the attitudes and feelings of the persons involved. Planning then becomes more realistic and more apt to preclude factors which might promote later discontents and strains.

Too, we notice that this nurse could "help both patient and family see their parts in the recovery program" and she "helped them plan." She did not assume too much responsibility for recovery, as nurses and doctors sometimes do. She did not say, "Do as I tell you and you will get well." Apparently she was objective and secure enough to remember that no one but the patient can assume that responsibility. Medical and nursing care can help.

But advice was given. Advice can be therapeutic when it supports and assists people to attain desired and desirable goals. One does not throw troubled people entirely on their own resources. There is need for rare good judgment.

Although the manner in which all this was done is not recorded, I would like to believe that the steady progress depicted was because the nurse was using her personal and professional equipment with *consciousness*. I would like to think so because it would mean that she can do so in other and different circumstances with a minimum amount of dependence on chance. If all the progress described was because she sensed attitudes and propropitious times (intuition) that is fine. If it all happened because of her conscious awareness of the emotional factors involved, that is better.

Placing a gate at the patient's doorway was an excellent move. We know that refusal to stay in bed or away from the family is frequently due to concern about the welfare of other members of the family. In this instance we can surmise that this simple device allayed anxiety in both mother and other members of the family. It means that the nurse probably knew about the emotional needs of little children as well as of their parents. This helped to promote a more peaceful environment for this family.

The care given to the timing of visits and timing of advice also indicates sensitivity to strains and their alleviation. We may deduce that this nurse was truly focusing her attention on the needs of the family rather than on her own desires to "get things done." She could wait a little while before suggesting physical examinations for the family. She apparently knew the moments at which introduction of new activities in the management of her own household would be comforting as well as constructive for the mother.

It is not my intention to analyze the whole account, but rather to point out some of the highlights. There are many other factors suggested. The nurse's knowledge of nutrition, of diversional and occupational therapies, of community resources, medical and social—all these were brought into the picture and together made for a fine example of what is meant by "family nursing."

MARY L. FOSTER

THE NEW MOTHER COMES HOME.

. . .and asks the nurse, "Why am I so tired?" The author gives some answers to the question in describing her experiences with early ambulation for maternity patients.

MARIE PABST, R.N.

THE UNPREPAREDNESS of maternity patients to return to their own homes after discharge from the hospital under the program of early ambulation, is reflected in their questions. They ask the public health nurse: "Why do I tire so easily after being home a day or two?" "Why do I feel so much weaker at home than I did in the hospital?" "Why didn't someone tell me I would be so tired when I got home?" "Why didn't the nurse in the hospital tell me that the visiting nurse could help me overcome the blues?" These and countless other questions pose a direct problem in maternity nursing. They show a need for continuity in nursing supervision after discharge from the hospital.

The order of the day is early ambulation for most maternity patients. It carries with it a personal satisfaction vitalized by the feeling of self-dependence. Released from the cumbersome gait of pregnancy, allowed to by-pass the traditional lying-in period, the patient has a sense of exhilaration. While in the hospital she is not conscious of the professional direction which keeps her activities under control, the routines tailored to her limited strength. Because she has a degree of self-dependency and is not confined to the hospital bed, she is discharged early from the hospital. This might be reasonable if further professional nursing service were provided. But even when home nursing is available in the community, patients are not always told about it by the nurse in the hospital. There is a marked tendency to neglect the nursing needs of ambulatory patients, in spite of the fact that these patients require nursing care and guidance just as much as the bed patient.

The fifth or sixth day after childbirth is usually the day of discharge from the hospital. The mother has looked forward with joyful anticipation to being back in her own home, fitting the baby into the new nursery, getting dressed up in clothes she could not wear during pregnancy, taking care of the baby, and numerous other activities about the house that had given her happiness in the past. This was the dream picture. The trip home seemed a little wearisome; the baby didn't like his new bed and his new quarters and cried a great deal.

Early on the second day home, friends dropped in to see the baby. The perineal stitches hurt and her nipples were sore. Why didn't her friend Mary do something to help instead of sitting there talking? She could prepare the formula or bathe the baby for her. Her mother seemed very awkward and nervous when she handled the baby. Why did the baby seem so distressed? Maybe he had a pain in his stomach. She couldn't

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remember what the nurse in the hospital said about taking care of the cord. Her husband seemed very helpless. It was his child too, wasn't it? Why hadn't he made it his business to know how to care for his child? She could not be expected to shoulder all responsibility. Her mother brought food for lunch and dinner. She wasn't hungry so she didn't eat lunch. She put everything into the refrigerator. Her husband came home; he was hungry. Everything was ready; it would only take a minute to warm it up and get it on the table. Again she had no appetite. She looked and felt woebegone and discouraged. The thought flashed through her mind, "It would be nice to be back in the hospital again."

Days went by, and with the close of each day her weariness increased. Finally her husband called the physician who ordered her to bed. Her mother came to take care of her and the baby. At this point the physician called the visiting nurse. Mrs. A. was a bed patient for nearly a month She was probably putting the cart before the horse when she said, "If I had only had the nurse the day after I came home things would have been different."

It seems simple when we see the situation in retrospect. But it serves to illustrate that early ambulation may have problems all its own. The hospital staff has a responsibility for the health and welfare of the patient beyond the hospital door. Under this program of early ambulation and discharge of patients, the need for a close tie-up between hospital and home nursing services is greater than ever before.

Case records in the files of the Visiting Nurse Association give ample proof of the inherent needs of the maternity patient during early ambulation. Unless there is better understanding of these requirements by all who give nursing service to her, there is danger that values anticipated for early ambulation will be lost. It has been said, "Twenty years from now we will be better able to judge the values in early ambulation." It will be a source of regret if through lack of foresight on the part of the nursing profession, preventable, damaging conditions are allowed to develop.

THE ONE THING to which the new mother looks forward with the keenest anticipation, is making a place for the baby in the family circle. However, none can minimize the adjustments which usually accompany the addition of any new person to the home. When that person is only five days old, with a great need for personal security as well as physical care, and the mother has limited physical resources, a problem exists. The far-reaching nature of this problem can be evaluated in terms of its influence on the baby. The little newcomer starts his life in a hospital environment where routines are not too well adapted to his future living. Then his habit patterns are interrupted before they have been well established. His transfer to a new environment plays a considerable part in his reaction to it. In this transition period the mother, depleted in strength, often finds the situation beyond her control. If in addition to these normal problems, there is an immature husband, inadequate housing—a common occurrence today—and economic strain, the new mother becomes depressed and weary in mind and body.

Many of these difficulties were present in the case of Mrs. B., an attractive, intelligent young woman twenty-five years of age. At the time she called VNA, Mrs. B. had just delivered her first baby and was staying with her parents during the postpartal period. The home was comfortable and financial resources seemed adequate. Mr. B. was in school in another city.

The patient had been under close private medical care throughout her pregnancy, but had had no nursing supervision. She was totally unprepared for the physical aspects of labor and the delivery and was fearful on entering the hospital. Her fears were not overcome during her five days there. She expressed a dislike for the hospital and was anxious to get away from it and return to the comforts of her own home. While in the hospital someone told her about the visiting nurse. But since she was very excited about getting home, it slipped her mind. It was not until forty-eight hours later as she wept with discouragement that she remembered.

What were the troubles that made life so

difficult? It is easy to see that the mother herself needed counseling and nursing supervision. Her labor had been a long one followed by a forceps delivery and a deep episiotomy, which at the time of my first visit, was still painful. She had large and edematous external hemorrhoids, which were painful. Her nipples were sore and bleeding from excessively long nursing periods. Her appetite was poor; she was constipated; she had had little rest since her return home; and she was emotionally upset.

When Mrs. B. opened the door for me, she looked so weary I wondered if she were sick or just tired. She spoke in a hushed voice as she led me to the living room and introduced me to her mother. I soon learned that the mother was a cardiac and that present problems were affecting her health. The patient hastened to explain that this was one of the brief periods when the baby had fallen asleep, and she was afraid he would awaken. Excitedly she revealed her problems with the baby. He cried constantly. Maybe the circumcision was hurting him. She was afraid to apply the dressing the way they showed her in the hospital because she might hurt him. The cord worried her very much. She had been advised in the hospital to apply mercurochrome to it, but she was afraid to touch it. Mother was no help. She had never seen a baby's cord before. Maybe the baby didn't get enough to eat. She had nursed him on both breasts so long that her nipples were sore. The doctor had told her to give the baby a formula, if necessary. But she couldn't tell if he got enough or not, and she knew it was good to nurse a baby.

There was nothing unusual about this situation. Depressed as the mother was on the first visit, within a relatively short time she was able to enjoy her baby and the care of him. If the nursing service had been made available to this mother within twenty-four hours as a natural extension of hospital care, many difficulties would have been avoided. On the other hand, if Mrs. B. had not gotten help when she did, she might have had to return to the hospital for care. Gaps in nursing service at this precarious time are sometimes responsible for undoing the progress made in the hospital, with a marked loss in the general physical vitality of the mother.

The young mother just home from the hospital often undertakes duties unsuited to her physical condition, when there is no one to supervise her. She mistakes the permission granted her to be up and about as a go-ahead for activities which are far too strenuous for her then.

IN SOME CASES, housekeeping problems must be solved by the nurse. This was true in the case of Mrs. D. who called the VNA during her eighth month of pregnancy.

Mr. and Mrs. D. were newcomers to Milwaukee where Mr. D. was attending medical school. The family consisted of Mr. D., aged twenty-nine, Mrs. D., twenty-seven, and a daughter of seventeen months. They had no relatives or close friends in the city. Mr. D. had a heavy school schedule which occupied his time completely, and Mrs. D. was often lonely. She felt her husband was not interested in her and the little girl. Her morale was lifted by my visits, but there were other problems to be solved, such as the care of the child during the mother's hospitalization and following her return home. The family was referred to the Family Service Association. Arrangements were made to place a housekeeper in the home during the hospitalization of Mrs. D. and for ten days thereafter. The mother was high-strung and nervous and after childbirth her condition was aggravated by a persistent headache resulting from spinal anaesthesia. Through the housekeeper's help the immediate needs of the family were comfortably handled and rest periods for the mother made possible. However, long-range planning was necessary to help the mother develop broader contacts and interests in the community. The teamwork of the visiting nurse and the social worker resulted later in the use of other community resources, promoting a more normal social life for the family. In this case the rapport established by the nurse in the antepartal period served as a springboard for constructive help in the postpartal period.

New discoveries in medical science and

(Continued on page 414)

SUMMER CARE OF INFANTS

A. R. NELSON, M.D., and
RUTH M. McCULLAGH, R.N.

THE PUBLIC HEALTH nurse has enviable opportunities to teach sound infant care during the hot summer season. Whether she works for a health department, board of education, visiting nurse service, or industrial firm, the nurse is in contact with many parents of small babies. She has an excellent chance to promote infant health and to cut down on the summer toll of infant ailments.

First on the nurse's teaching list should be infant hygiene, especially important during hot weather. She may point out to the mother that her baby needs at least one bath with warm water and mild soap every day and, when temperatures soar, one or more tepid sponge baths. A mother should know how to treat heat rash, not uncommon in this season. It comes from excessive perspiration, due to extremes in temperature or too much clothing. The affected parts should be sponged frequently and dried thoroughly. The mother can also relieve it by powdering with starch and by dressing the baby in light cotton clothing. The treatment is essentially the same for chafing, more common in fat babies than in underweight ones.

The baby has a great need for liquids during the summer, when the old adage of fluids internally, externally, and eternally is especially applicable. The baby should receive three or more ounces of fluid per pound body weight every twenty-four hours. In addition to an abundance of cool boiled water, the mother may give diluted fruit juices and tomato juice. Older infants may also have clear soups, broth, and bouillon. The mother may dilute the infant's fruit juices with from three to five parts of cool boiled water. This is done to increase fluid intake to make up for fluids lost in elimination.

When a mother complains about her baby's appetite, the nurse may reassure her, explaining that this is probably temporary and normal, and not a cause for alarm unless other symptoms develop. In hot weather the infant does not need so many calories. The mother should, however, continue the baby's cod liver oil or its equivalent, perhaps in reduced amounts, during the summer season.

The nurse should also teach the mother why the baby's food must be kept clean and refrigerated. Germ life thrives in unprotected food during the hot weather. Flies and hands may contaminate food. The baby's food should be kept in the refrigerator and prepared carefully. Terminal heat treatment of formulas is recommended.

Most mothers tend to overdress their babies in summer. The baby does need a minimum of covering since clothing acts as an insulating material preventing heat loss from the skin. A diaper and possibly a

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sleeveless cotton shirt or band may be enough when it is very hot. The mother must adjust the baby's clothing to changes in temperature promptly.

THE NURSE MAY also show the mother how to make the most of sunlight. In many parts of the nation, the summer season offers the best chance for giving the baby the benefit of the sun's rays. The nurse should point out the value of sunshine in the metabolism of calcium and phosphorus, the prevention of rickets, the development of strong teeth and sound bones, and the building up of resistance towards the infections common during the winter months.

The mother should know that sun baths should be started carefully. The nurse may suggest that to start with the mother expose certain parts of the baby's body, front and back, for a very few minutes once or twice daily. As the baby develops tolerance, the mother may gradually expose more of his body for longer intervals. She should be very careful that the sun does not shine directly into the baby's eyes. When the temperature is extremely high, the baby should have his sunbath during the midforenoon and possibly late in the afternoon, when the sun's rays are less potent. The amount of the baby's tan is not necessarily an index of the benefit he has received from the sun.

The nurse may also help the mother plan for the baby's playtime. The summer season offers wonderful opportunities for fresh air and exercise, so vital in growth and development. The mother and the nurse can discuss whether the baby should be confined to a crib or playpen, whether he should play within the home, on the porch, or in the yard. The baby's play area is pretty much an individual problem, depending on his age and the circumstances and wishes of the family. Too much stress can not be put on the need to protect the baby from flies and other insects, and, in some cases, even from vermin. The baby needs at least one, and preferably two, naps a day.

Sometimes mothers feel that immunizations should be postponed until cooler weather. The nurse may point out that summer immunizations against smallpox, diphtheria, whooping cough, and tetanus can protect the baby later in the year when certain of these infections are rife. There is no reasonable excuse for postponing these immunizations unless the weather is excessively hot.

A mother should learn how to guard against gastrointestinal infection, always a lurking danger in summertime, and what to do if her baby develops diarrhea. The mother should understand that ample fluids give the baby at least moderate amounts of carbohydrates and inorganic salts. These are essential in preventing acidosis and mineral depletion.

Infant diarrhea may be non-specific in character but it may also mean a serious infection, requiring prompt treatment. The nurse should instruct the mother to send for the family physician if the baby has more than one or two watery bowel movements a day, whether or not blood or pus is apparent. The mother should not feed the baby any solid food nor give a laxative or enema until she has had professional advice.

Special efforts should be made to keep infants and young children away from various insect poisons, commonly used in summer months. If poisoning is suspected, the family physician should be summoned at once, or the patient should be taken very promptly to the nearest hospital. While waiting for the doctor, the mother or nurse may try to make the baby vomit by tickling the back of his tongue or throat. At times, plain water or warm water with a little table salt or mustard dissolved in it will produce emesis.

By teaching these basic principles to the mothers she works with, the public health nurse can promote a happier, healthier summer for the babies in her community.

The Story of the New NOPHN Cost Analysis Method

MABEL REID

The chairman of the committee that has seen the study of costs in public health nursing through from 1946 until the recent publication of the manual reviews the history of the undertaking, the experimentations in and the development of the method, and what may be expected by an agency from application of this new method of cost accounting.

COST ACCOUNTING IS one of the most valuable tools available to the administrator in public health nursing as it is to the executive in industry. NOPHN has provided such a tool for many years, has kept it oiled and sharpened, and has modified the design from time to time to keep abreast of current needs. A brand-new model has just emerged successfully from extensive testing and NOPHN now proudly offers it for your use.

Of what value to a public health nursing administrator is such a tool? A system of cost accounting provides the information needed for financing a service and setting up a budget; it establishes a base from which a fair selling price may be determined if service is to be sold; but, most important of all, it points the way toward efficient management. In the process of assembling data needed for cost analysis, a spotlight is thrown on many aspects of an agency's administration.

The design for the first crude model of this tool, cost accounting, which was sponsored by NOPHN, was formulated at a Biennial Convention held on the West Coast in 1922 when plans were laid for a study to evaluate the quality of visiting nurse work and determine the cost per visit. That early project was the work of a committee with the all-inclusive title, "Committee to Study Visiting Nursing."

In 1927 the NOPHN body which handled questions relating to costs was known as the Service Evaluation Committee, emphasizing the relationship of cost accounting to good administration. In that year, under the chairmanship of Dr. Haven Emerson, another study was undertaken to determine what changes should be made in the method for computing cost per visit. The report of that committee was published in 1932 under the title "Principles and Practices in Public Health Nursing including Cost Analysis." This second NOPHN model of cost accounting presented not only the revised method of cost computation but sought to outline standards and accepted procedures in all phases of public health nursing administration.

More recently problems relating to cost have been handled by the NOPHN Cost Analyses Committee. But always there has been

Miss Reid is statistician, Visiting Nurse Service of New York.

an NOPHN body to guide agencies in problems of cost accounting and to interpret and modify the National Organization's recommendations pertaining to cost.

About five years ago it became apparent that this second model of the cost accounting tool which had done so much to help visiting nurse associations achieve a reputation for business-like efficiency was becoming obsolete. Something more than the average cost per visit was needed. Agencies wanted to know the cost of clinic service, the cost of part-time service to industry, the cost of providing field work experience and observation for students. With the idea of producing a companion model to this famous Model II, a subcommittee was appointed to work out a method for computing cost per hour which would supplement the standard cost per visit procedure. Almost immediately, the project gave way to a general overhauling of our theories of cost analysis and a broad new study was undertaken, the object of which was to be a method of cost accounting flexible enough to yield all kinds of cost information —the cost of a unit of nursing service, such as a home visit or a clinic session, the cost of a time unit, such as an hour of industrial plant nursing or a student day, or the cost of an entire program, such as maternity nursing or tuberculosis nursing. Agencies which may not be immediately concerned with the average cost of a home nursing visit are frequently vitally concerned with the cost of a program for which money may be available through state and federal appropriations.

The United States Public Health Service and the Metropolitan Life Insurance Company financed the undertaking and both of these agencies as well as the John Hancock Mutual Life Insurance Company lent personnel for varying periods of service. Margaret Arnstein served as director during the first year, Katharine Peirce and Eleanor Palmquist carried on during an interim period and Elizabeth Stobo directed the project during its last two years. The method was worked out with the aid of the Trundle Engineering Company of New York. Mary Elizabeth Bauhan handled the statistical aspects of the study during its final year. Health officers, accountants and research experts and leaders in various fields of public health nursing served on the study committee. And everywhere, public health nurses cooperated to a degree that would be truly amazing to anyone unfamiliar with the ways of public health nurses.

SOME OF YOU may remember that at the last convention in Chicago, it was reported that a new method of cost accounting had been evolved and that considerable attention was being given to technics for tabulating data which would make the method a useful and practical tool for agencies of all types. At that time it was announced that a series of institutes would be held throughout the country to teach the new method to local administrators. In the months that followed, there were seventeen such institutes lasting approximately three days each. Those who attended were asked to apply the method, computing the costs of their own agencies' programs for the year 1948, and to share the results with NOPHN. This plan had two objectives: first, it would provide an extensive test of the validity of the method itself under varying conditions and, secondly, it would indicate something about the actual cost of public health nursing service.

It is a source of considerable pride to report at this time that 73 agencies completed this assignment within the time limits set. Twenty-three states from Connecticut to California, from Minnesota to Mississippi are represented in the group. They include agencies of all sizes ranging from those employing fewer than five nurses to those whose staffs number more than one hundred nurses. It was to be expected that the visiting nurse associations which have long been cost-conscious would respond and fifty did; the noteworthy feature of this study is the fact that fourteen official agencies supported by tax funds were sufficiently interested in cost accounting to participate voluntarily and carry studies through to completion. Nine additional agencies combining the functions of official and nonofficial organizations also are represented in the final report. Some of the agencies maintain diversified, complex programs;

others limit their work to certain specialized services. In every instance, the new method of cost accounting proved workable. These 73 agencies have demonstrated that the new model of this administrative tool can be recommended for use in every type of public health nursing organization which wishes to know the cost of any and all kinds of service rendered.

The experience gained from teaching the general method at the institutes and in working with individual agencies on specific problems has been incorporated into the final version of the manual which may now be obtained from NOPHN.[1]

These 73 agencies have also made available an invaluable body of data relating to the actual cost of public health nursing service in 1948. This was no light to be hidden under a bushel, but in seeking ways to publicize the material the committee which guided the study was mindful of certain precautions. Proud as we are of the fact that 73 agencies, including 14 official agencies and 9 of the combination type, completed cost studies, we are well aware that these do not constitute a truly representative sample of all public health nursing in 1948. Rather, these are the agencies which were interested in cost analysis, and which possessed the facilities and the resources to carry through cost studies at their own expense within a limited time interval. The committee determined not to publish any average or median values which might be lifted out of context and misquoted as typical or standard costs. However, a report has been published which we believe will mark something of a milestone in public health nursing administration. This report may also be obtained from NOPHN.[2] In it, you will find tables showing the entire range of experience, grouped by geographic location, size of agency, and type of administration. If your agency was one of the pioneering 73, you will find it a fascinating experience to follow it through the 22 tables and 14 charts which constitute the report. You will find not only the cost of an average visit, but separate costs for antepartal, postpartal, newborn, infant, preschool, school, and adult health supervision visits, for tuberculosis visits, orthopedic visits, other morbidity visits, visits to patients not at home, et cetera. You will find how much nursing time was required for each type of visit, not only in the home with the patient, but how much time was required in preparation and in travel. For example, nurses in my own organization, the Visiting Nurse Service of New York, have been both sobered and enlightened by the knowledge that for each 30 minutes spent with a patient (the average length of a visit in 1948) they spent 16 minutes in preparation and 11 minutes in travel. From the report we learn that our experience represents neither the minimum nor the maximum among agencies employing more than one hundred nurses.

IF YOUR AGENCY provides public health nursing services in clinics, you will find the cost of a clinic session, the cost per patient attending, the nursing time required for the session divided into activity time, preparation time, and travel time. Similar information is available for every other type of nursing service, such as group teaching, school nursing, industrial plant nursing, et cetera. Agencies with student programs will be interested to see how much time is spent on students by different levels of personnel, what proportion of the time of students is productive to the agency in terms of staff replacement, and the range of cost for a student day. Similar information is available concerning staff education programs. To draw again from personal experience, in a recent discussion at a supervisors' meeting of the number and kind of staff education conferences to be planned during the coming year, the thinking of the group was influenced by the knowledge that the agency was spending approximately $20 per month per nurse on its formal program of staff education and that more than 3 percent of staff nurse time was being spent in this type of activity.

You will find in the report not only how staff nurse time is distributed but also how supervisors spend their time, what percentage goes into activities requiring only staff nurse ability, and what part is spent in actual supervision. You will find how agencies' budgets are distributed among various kinds

of nursing activities. In each of the 73, visiting accounted for the largest slice. You will find how costs are distributed among different kinds of expenses, how much of the whole is accounted for by the salary cost of staff nurse work, how much by supervision, transportation, general overhead.

This report is almost sure to whet your appetite. Riffle through its pages and you will want to study your own costs and fit your agency into the composite picture presented by those history-making 73. You can.

Last fall the NOPHN Board of Directors gave its official approval to this new cost accounting procedure and voted to provide assistance and guidance to individual agencies applying it to their own cost problems. Write to NOPHN for suggestions about adapting the method to your needs.

The New Method

The new cost accounting procedure consists of three main parts. The first step belongs to the administrator. She must think carefully about the functions of her agency and the reasons for studying cost and decide what cost centers will be needed. *Cost center* is the term applied to any service, program or activity for which costs are to be computed. All activities of the agency must be taken into consideration so that one service will not unwittingly be charged with the expense of another. Cost centers may be subdivided to yield as much detail as desired, provided statistical counts of service are kept with the same degree of detail. For example, the agency which wishes to know how the cost of a visit to a cancer patient differs from the cost of other morbidity visits must keep a separate count of the number of cancer visits its nurses make in the course of a year. NOPHN is prepared to advise administrators in this important planning phase, and will help you set up the cost centers which will best serve your individual needs.

The second step in the procedure concerns your entire nursing staff. Through job analyses and sample time studies, the average time required for a unit in each cost center is established: the time required for a visit, for a clinic session, a student day, et cetera. One of the rather pleasant surprises which emerged from this extensive testing of the cost accounting method was a general impression that staff nurses, properly prepared, found keeping an accurate record of their time for cost purposes an interesting and stimulating experience. From NOPHN you can obtain a supply of the time sheets and instructions which your nurses will need. Three plans have been worked out for summarizing time study data. Complete sets of worksheets are available for those agencies with the facilities and the inclination to tabulate the material by hand. Agencies with access to mechanical tabulating equipment can obtain punch cards, wiring diagrams, and instructions from NOPHN. For those agencies which are not equipped to handle the job themselves, arrangements have been worked out whereby they may send their time sheets to the service bureau of International Business Machines Corporation to be tabulated mechanically. NOPHN will quote prices and advise agencies on the relative merits of these three plans in individual situations.

The third part of the cost accounting process is a computation job. The results of the time study are related to the annual statistical counts of service to determine how much nursing time has gone into each cost center, and this becomes the basis for distributing to the different cost centers the various types of expenses incurred during the year. I hesitate to mention the federal income tax in connection with the NOPHN cost study because the associations aroused may not be entirely felicitous and my task today is to do the kind of public relations job which this exciting new NOPHN model of the cost accounting tool deserves. But I thought you might be interested to know that during the years that have gone into the preparation of the manual which describes the method, the committee has used the income tax schedules as a guide in its effort to provide a set of forms so complete that every detail needed in the computation could be consistently worked through simply by filling out the forms in orderly sequence. These forms are available from NOPHN. Although income tax schedules may be perfectly designed to take

care of all types of incomes, many people find it advantageous to seek outside help. It is much the same with this third phase of cost accounting. After the necessary information has been assembled, any intelligent person with a calculating machine and a set of work-sheets can carry through the computations and produce the required results, but many agencies will find it economical to ask NOPHN to do this part of the job. The National Organization is prepared to offer such service to a limited extent at a nominal fee.

SO THERE IS the new model of the cost accounting tool. It is more complex than the outmoded models of 1922 and 1932 which have served public health nursing well in the past, but it is designed to accomplish far more as a tool than was dreamed possible when those earlier models were fashioned. Though it is more complex in design, a great deal of effort has gone into making it mechanically easy to operate.

Many of the 73 agencies which participated in the cost study by computing their own costs for 1948 are now studying their 1949 experience. Other agencies which planned too late to be included with the 73 have since used the cost accounting tool. There are a number of local studies going on at the present time under NOPHN guidance. The United States Public Health Service has trained personnel to assist with local studies. In passing, it is interesting to note that the new model of cost accounting, designed for public health nursing, is attracting attention in other fields. A group of sanitary engineers in Seattle, Washington, has adapted the NOPHN method to its own use and is now applying it to the field of sanitary engineering. One of the 73 agencies represented in the cost study report is part of a health department which computed not only the cost of nursing but of all other services as well. After an article on the cost study appeared in the *American Journal of Public Health,* requests for the manual were received from the World Health Organization and from foreign countries.

There was never a piece of research worth its salt which did not point the way to further research and study. One measure of the value of the NOPHN cost study which has just been completed is the fact that already plans are under way for a new project. The cost study report emphasizes that no two agencies are alike. There is great variation in the cost of service. For example, among the thirty agencies which computed the cost of nursing service for child hygiene clinics, the cost ranged from $5 to $47 per session, and from 59 cents to $2.53 for each child who attended a session. Other types of service show even wider ranges in cost. In general, agencies of the combination type appeared to be somewhat more homogeneous than either voluntary or official agencies, not only with respect to final costs but in the various factors which affect the final result. The report is set up in such a way that it is possible to trace these factors and to understand some of the reasons for variation in cost. One agency operates on a higher salary scale than another, supervision cost is high in certain agencies, overhead costs vary considerably, more travel time is required in one place than in another, some agencies spend a large amount of preparation time in proportion to actual service time. Yes, it is easy to understand why costs vary. But inevitably, the question arises, does a high cost imply a high standard of service to the community or is there evidence of inefficiency and poor management? The administrator who has analyzed her costs is in a position to answer this question.

Similarly, this study of costs in 73 agencies has given NOPHN data upon which to base further study about the relation of cost and good administrative practice. Those who have worked on the cost study to date find the questions posed by the information now available a tantalizing challenge. We seem to be on the threshold of a thrilling new era.

It is now proposed to obtain cost information from approximately thirty more agencies of the official type and from areas not adequately represented in the report, to investigate some of the relationships between different cost factors, and to study intensively practices in certain selected agencies to discover how efficiency and good management can help provide a high quality of service at

a cost communities can afford.

A university student recently asked the question, "Should an agency be proud of low cost service when we are struggling to raise salaries?" It seems to me that if a satisfactory scale of salaries for public health nurses is to be achieved, it is imperative that public health nursing administration be as efficient as possible. Cost accounting is a means toward that end.

Summary

Plans outlined for the cost study two years ago have been completed. The new model of the cost accounting tool has been tested extensively and has stood up admirably under all conditions. In the course of testing, a body of information relating to public health nursing costs has been assembled in a report which promises to be reference work of great value. All of the experience gleaned in testing the method in individual situations has been incorporated into a manual explaining how to make a cost study in a local agency. NOPHN is prepared to offer material, advice, and service to help agencies use the new tool effectively. And, finally, new research has been planned to extend the results so far obtained one step nearer that elusive goal of understanding how to evaluate the quality of public health nursing service and how to achieve truly efficient management and administration.

[1] NOPHN. Cost ananlysis for public health nursing services. N. Y. National Organization for Public Health Nursing. 1950. 104 p. May be purchased until July 31st for $1.50. Price thereafter $2.00 a copy.

[2] NOPHN. A report on the study of costs in public health nursing. N. Y. National Organization for Public Health Nursing. 1950. 78 p. 75c a copy.

Presented at the NOPHN Business Meeting at the Biennial Nursing Convention, San Francisco, California, May 9, 1950.

The New Mother Comes Home

(Continued from page 406)

changes in medical technics create a concurrent necessity for new methods and patterns in nursing service. In few areas of the nursing program is continuity of nursing supervision more dramatically indicated than in the case of the maternity patient who leaves the hospital early. The very nature of this freedom indicates the need for controls. Furthermore, in the hospital, the physician usually sees the patient daily, but when she returns home he sees her only if serious problems arise. The nurse, a natural link between the physician and patient, can often prevent serious medical problems from developing. It seems obvious that a working relationship between the hospital, the physician, and the community nursing service is essential to insure desired nursing care for maternity patients.

It is important that the nursing requirements of the maternity patient be well understood by all who participate in her care. These needs are physical, emotional, and social. The public health nurse not only provides a direct service to the patient but has the additional responsibility of helping medical and hospital personnel to understand the difficulties of the discharged maternity patient. The observations made by the public health nurse of problems experienced by the new mother today in the home will result in constructive progress if intelligently interpreted to the medical and nursing team who do not have the advantage of first-hand contact with developing difficulties and needs.

New Books
And Other Publications

PRINCIPLES AND PRACTICE OF THERAPEUTIC EXERCISES

Hans Kraus. Springfield, Illinois, Charles C. Thomas Company, 1949. 309 p. $6.50.

This book is presented in simple, practical, and understandable language.

All graphs and illustrations are essential, and the conciseness of content leaves little room for confusion on the part of the reader. There is a fine continuity of subject matter beginning with the physiology of muscle power, measurements, analysis of body disfunctions, and application of therapeutic exercises to the particular field involved. This is positively stated so the sum of the parts adds up to total the "whole" individual.

Dr. Kraus seemingly has a warm personal regard for the handicapped person. He also stimulates cooperation of the medical-surgical-therapist rehabilitation team.

Students of physical therapy as well as the experienced worker in the rehabilitation field might well use this text for reference.

—Frances A. Coleman, *R.N., B.S., P.T., Visiting Nurse Association of Brooklyn.*

FACILITATION OF INTERSTATE MOVEMENT OF REGISTERED NURSES

Bernice E. Anderson. Philadelphia, J. B. Lippincott Company, 1950. 171 p. $4.00.

Do not be misled by the title of this book. It is interesting and deals with down-to-earth problems encountered by the many nurses who move from state to state and the stay-at-homes who work on problems of registration.

Miss Anderson's study was carried on as part of a program of graduate study at Teachers College, Columbia University. Her report is based on data obtained from forty-five states, the District of Columbia, Alaska, Hawaii, and Puerto Rico. The laws of all states current on January 1, 1949, were studied in relation to the data obtained. Record forms, board rulings, and policies used in interstate licensure were reviewed. She traces the historical development of the legal control of nursing practice and gives helpful explanations of the little understood legalities. The present restrictions in interstate licensure are clearly outlined and efforts already made to eliminate or minimize these restrictions are described. The concluding chapter of recommendations is excellent and will be a large factor in helping us to solve some of the problems connected with interstate licensing.

While studying this report you will want to have a copy of a current nurse practice act at hand. You have a few surprises in store even though you think you know the nurse practice act of your state.

—Christine Mackenzie, *Assistant Chief, Bureau of Public Health Nursing, California State Department of Public Health.*

FAMILY FARE, FOOD MANAGEMENT AND RECIPES

Bureau of Human Nutrition and Home Economics, Agricultural Research Administration, U. S. Department of Agriculture, 1950. 25c. Send order to Superintendent of Documents, U. S. Government Printing Office, Washington 25, D.C.

The booklet is made up largely of recipes which may be found in any standard recipe book. There are seventeen sections, eight of which are devoted to recipes. The sections on main dishes and soups include suggestions after each recipe for fitting the dish into a menu for a complete meal. This ought to be helpful to the homemaker as she plans her weekly menus.

The booklet offers hints to the homemaker which will help her to serve enjoyable meals, keep her family well nourished, practice thrift when necessary, and save time and energy

wherever possible. The nutrition section aims to bring her up to date and show her the importance of the right kinds of food for her and her family for health. The food planning section shows an orderly way to provide meals that contain the nutrients in the amounts each member of the family needs. The cooking principles introduced have the modern idea of conserving the nourishment and the "appetite appeal in the food." The sections on food buying, storing, and measuring contain some good pointers on thrift. These sections could have been more inclusive at the sacrifice of some of the recipes, for such material is very much appreciated by the young homemaker.

Family Fare should be a useful addition to the kitchen shelf library.

—EDITH M. SHAPCOTT, *Nutrition Consultant, Visiting Nurse Association of Brooklyn.*

ACHIEVING MATURITY

Jane Warters. New York, McGraw-Hill Book Company, 1949. 349 p. $3.00.

This text presents the principal developmental experiences of adolescents: physical, intellectual, emotional, moral and ethical, interpersonal, and social. Its main purpose, in the words of the author, is to "present in nontechnical language certain findings of recent investigations of this period in a way that will help young people to understand the nature of their problems, to discover the universality of certain of these problems, to become acquainted with some important sources of aid, and to acquire knowledge of certain principles of mental hygiene which they may use in dealing with present problems and in building for the future."

This is a laudable and highly ambitious undertaking and one wonders if it is possible to attain these objectives in any one volume, however well written. The book, written for the adolescent, seems too lengthy. The author frequently quotes directly from an extensive and good bibliography, and although there are many illustrations from the author's experience one might ask if such detailed information might not be more anxiety-producing than helpful to the self-critical adolescent.

Individuals desiring understanding of the adolescent period will find better sources than this book. This reviewer questions whether the young people to whom the book is directed will find it meaningful. It seems doubtful that a factual presentation of research in this field of adolescent growth and maturity can replace the personal contact with an understanding individual such as the author.

—ROSE W. COLEMAN, *M.D., Public Schools, Bronxville, New York.*

TRAINING FOR CHILDBIRTH

Herbert Thoms. New York, McGraw-Hill Book Company, 1950. 114 p. $3.00.

In Training for Childbirth Dr. Thoms has presented the Yale program of natural childbirth with rooming-in. The recent trend of allowing the mother to be present in mind as well as body at the birth of her child is gaining great momentum in this country. The movement was started in England by Grantly Dick Read and has been enthusiastically promoted by recent articles in the lay press. The Yale Clinic has had more experience with this technic than any other teaching unit in this country so that it is both timely and fortunate that the head of this service, Dr. Herbert Thoms, should present this excellent review of its methods and results. The material is well organized, concise, and yet detailed enough to make it a very helpful guide for those who are interested in starting a hospital training program of natural childbirth and rooming-in. The book is highly recommended for nurses, doctors, and physiotherapists who are working in this field.

—ARTHUR V. GREELEY, *M.D., Obstetrical Department, New York Hospital.*

MENTAL HYGIENE IN PUBLIC HEALTH

Paul V. Lemkau. New York, McGraw-Hill Book Company, 1949. 396 p. $4.50.

Dr. Lemkau has written an important book. It is a classic in its field. What it has to say is so sound and its basic premises so clear and understandably stated that probably for years it will be a textbook and source of

reference for those interested in the public health aspects of mental health. Administration of such a program is discussed with brief descriptions of the setups in various states.

Another and larger section describes growth, personality development, and common mental health attitudes at various age levels from infancy through adolescence and middle age to old age. This part contains sound information and helps the reader to develop mental hygiene knowledge that should be of everyday usefulness.

A short appendix presents a brief survey of psychopathology useful for reference and differential diagnosis.

The scope of the volume should be of vast interest, not only to public health personnel but also to teachers and educators and those whose service relates to the public health field.

—Exie E. Welsch, *M.D., Chief, Children's Psychiatric Clinic, Out-Patient Department, Payne Whitney Clinic, New York Hospital.*

CEREBRAL PALSY

Help at Last for Cerebral Palsy. Eugene J. Taylor. Public Affairs Committee, 22 East 38th Street, New York City, pamphlet No. 158. 1950. 20c.

This pamphlet is designed to acquaint the public with cerebral palsy, its causes and treatment, training for a job, and the groups and societies concerned with assisting the cerebral palsied. Recommended for parents and lay persons, and as a help to nurses in working with parents of the cerebral palsied.

DENTAL HEALTH

Everybody Smile. Pamphlet published by the American Dental Association, 222 East Superior Street, Chicago 11. 1949. 25 copies $0.50, discount on quantity orders.

A dental health education aid which may be used as supplemental reading in primary school; catchingly illustrated and conveying sound principles of dental health for children, teachers, and community agencies to stimulate a sense of responsibility in the youngsters.

EDUCATION

Occupied Areas Handbook. American Council on Education, 744 Jackson Place, N.W., Washington, D.C. 50c.

A directory of American nongovernmental organizations engaged in cultural and educational relations with the occupied countries.

Canton University Survey. M. G. Neale, Director. American Council on Education, *ibid.* $1.00.

Cultural Relations with The Occupied Countries. Edited by Harold E. Snyder and Margretta S. Austin, *ibid.* $1.00.

A report of the first national conference on the occupied countries, Washington, D.C., December 9-10, 1949.

GENERAL

New Discoveries in Medicine. Paul R. Hawley. Columbia University Press, New York. 1950. 134 p. $2.50.

A collection of lectures given at Columbia University in which the author discusses developments in surgery, medicine, and public health which have influenced the life and health of modern society. In three of the lectures Dr. Hawley comes to the defense of blood as a curative agent, describing the blood and plasma program of World War II and the incalculable value of the discovery of the Rh factor in the MCH field. The discovery of the antibiotics, et cetera, sometimes overshadows these facts. Some fascinating ancient superstitions about blood are revealed. The concluding portion of the book deals with the economic aspects of medical care and how increased costs are being met.

HEALTH EDUCATION

Fundamentals of Personal Hygiene. Walter W. Krueger. W. B. Saunders Company, Philadelphia. 5th edition. 1950. 284 p. $3.00.

SOCIAL WORK

Systems of Social Security, New Zealand. International Labour Office, Geneva. 1949. 67 p. 40c. Copies may be obtained by writing to I.L.O. branch office at 1825 Jefferson Place, N.W., Washington, D.C.

Health Educators at Work. Special issue of High School Journal, October 1949. 77 p. 50c. Discount on quantity orders. Order from Department of Public Health Education, School of Public Health, University of North Carolina, Chapel Hill, North Carolina. Make checks payable to "Special Issue, Health Educators at Work."

FROM NOPHN HEADQUARTERS

THE WHITE HOUSE CONFERENCE

The Midcentury White House Conference on Children and Youth to be held in Washington the week of December 3rd will have representatives from every state and territory. The proposed program has just been announced. Plans call for general sessions as well as information sessions and working groups.

Miss Fillmore, NOPHN representative on the Advisory Council on Participation of National Organizations, attended a council meeting on May 25th and 26th. The meeting was called to try to relate the purpose of the White House Conference with the programs of the national organizations and also to see how the members of the various organizations can work with the several planning committees to further the program of the conference and participate in it.

A great deal is expected of the post-conference activities which will put into effect and implement the recommendations from the conference. The Advisory Council is concerned with such plans as well as planning for the December meetings. As details are cleared, we plan to share these with our readers. In return, will you write and tell us what your communities and the nurses in them are doing as part of their participation in the Conference on Children and Youth?

MEMBERSHIP RALLY

The NOPHN Membership Rally always provides a happy break in the week of serious convention business, and this year's was an especially gay occasion. Again almost 600 NOPHN'ers and their friends gathered together for dinner—this time at the Mart Club in San Francisco.

The 1950 Rally owes so much of its success to the hard work of the local rally committee that we must take this opportunity to thank them once more. So thank you, Robina Walters, Mrs. Helen Chesterman, Mrs. Thelma Houwer, Mrs. Covington Janin, Minerva Kloster, Mrs. E. C. Sage, Virginia Dontanville, and Mrs. Gladyce Hardman for everything.

All these people and many more worked hard behind the scenes, but there were a few who held the stage, literally, and they are the troupe of delightful actresses who presented the skit, "The Clean-Up." Since all Californians are always surrounded by beautiful flowers, perhaps our artistes will accept this verbal bouquet in lieu of orchids. Forever and a day, whenever we think of scrubwomen—and that's pretty often—we'll think of Mrs. Marie Rexroth and Mrs. Jeri Beetz. And long will live the memory also of the general member and the public health nurse as played by Mrs. Viola Randall and Maurine Boyd. And thanks, too, to the alternate, Irene Yeik, who lent her support to the entire undertaking.

Those who missed the pleasure of seeing "The Clean-Up" may be interested to know the script was prepared originally for the YWCA by Barbara Abel, now of Community Chests and Councils, and was adapted for the field of public health nursing by the NOPHN staff.

The few short hours of the rally flew too rapidly on the wings of music and the hum of laughter. One last toast—or trio of toasts—to Mrs. Fannie Warncke, a most sparkling mistress of ceremonies, and to Mrs. Carl B.

Grawn and Mrs. Olive W. Klump, national general and nurse membership chairmen, respectively.

WHERE ARE THEY NOW?

We are eager to learn the present addresses of the following current members of the NOPHN. Can you help us locate them? Mail has been returned from the addresses given.

Mrs. Anita Speakman Arline, 710A College Avenue, Tempe, Arizona

Mary F. McBeth, 4338 W. Belle Place, St. Louis, Missouri

Mrs. Ruth Stansbrough, 35 Municipal Courts Bldg., St. Louis, Missouri

Rachel Blyth, 321 Saratoga Rd., Honolulu, T. H.

ADVISORY COMMITTEE ON NUTRITION

A small committee of nutritionists has been established to function in an advisory capacity to the staff of PUBLIC HEALTH NURSING. This committee will help us keep our readers informed about current developments in nutrition and will review materials for the magazine. Miss A. June Bricker of the Home Economics Bureau, Health and Welfare Division, Metropolitan Life Insurance Company, is chairman of the committee. The other members who are to serve for a two-year period are: Mrs. Frances M. Coles, VNA, New Haven; Dorothy B. Hacker, New Mexico Department of Public Health; Catherine M. Leamy, Children's Bureau, Federal Security Agency; Dr. Miriam E. Lowenberg, Rochester Child Health Institute.

STAFF CHANGES

Mrs. Helen Nelson, publicity consultant since early 1949, resigned to accept a position in the publicity department of N. W. Ayer & Son in New York. Mrs. Nelson was author of the special feature in the magazine, "It Worked In . . ."

Miss Geneva Stephenson joined the NOPHN staff in June as assistant director for public relations. She received her baccalaureate and masters degrees from Ohio State University and has done graduate work at Columbia University. Miss Stephenson has had extensive experience as a writer, publicity representative, and teacher. She has carried on public relations programs for the Columbus (Ohio) YWCA, the Second War Loan and National War Fund, for Marymount College, and the American Association of University Women. Miss Stephenson was editor of the *Bulletin* for the Ohio School of the Air and, as program director, edited all scripts used on that program. She edited manuscripts for advanced students in preparation for publication. Miss Stephenson has prepared many brochures, features, pamphlets, et cetera, for publicity and promotional purposes. She has taught various aspects of English and American literature and creative writing at Ohio State University, Marietta College, Maryland State Teachers' College (Towson) and Marymount College. Miss Stephenson is also the author of two historical novels, *Spring Journey* and *Melody in Darkness*, and of many stories and articles in leading magazines.

NOPHN FIELD SCHEDULE—JUNE

Staff Member	*Place*
Mary Elizabeth Bauhan	Philadelphia, Pa.
M. Olwen Davies	New Haven, Conn.
	Rochester, N. Y.
Marion P. Kerr	Baltimore, Md.
	Wilmington, Del.
	Cleveland, Ohio
Lois Olmsted	Springfield, Ill.
Dorothy Rusby	Morristown, N. J.
Anita Searl	Texarkana, Ark.-Tex.
	Dallas, Texas
Joan Sloan	Wilmington, Del.
Jean South	San Francisco, Calif.
Louise M. Suchomel	Cleveland, Ohio
Marie M. Swanson	Fontainebleau, La.
	Boston, Mass.

Elizabeth C. Stobo, in her California field trip, extending from the end of May through the middle of June, visited Glendale, Los Angeles, Santa Monica, Long Beach, Santa Ana, San Diego, Pasadena, Santa Barbara, San Francisco, Santa Cruz, and Sacramento.

May field trips not previously reported: Ruth Fisher, Burlingame, Calif.; Lois Olmsted, Birmingham, Ala.; Marie Swanson, Alameda, Calif.; and Anna Fillmore, Washington, D. C.

NEWS AND VIEWS

ELEMENTARY SCHOOL FOR THE CEREBRAL PALSIED

Three happy and responsive youngsters, their braces not too apparent as they sat rather unsteadily in small chairs in a special classroom at P.S. 118 in Queens, New York, smiled and even said a few halting words to visitors at the official opening of their school program on May 22nd. Normal in intelligence, these youngsters and nine others in the age group four to ten are enrolled in a long awaited elementary school program for the cerebral palsied.

Enthusiasm was high at the opening reception. Everyone agreed that cooperation and fine leadership had turned into a reality the hopes of several interested groups who set out in 1947 to do something for the thousands of cerebral palsied children in Queens who needed skilled training. A committee organized by the Queensboro Council for Social Welfare to enlist the potentialities of diverse agencies, decided to work for a complete program of education within a regular school unit.

The new program, jointly operated by the city Board of Education and Department of Health, is modelled after the only other unit in the city and represents a further experiment in the development of an administrative pattern for educating these handicapped children within the framework of regular school services.

The speech therapy room is set up, as are all the unit's facilities, for attention to individual problems. Whether by using the mirror, the toy telephone, large lettered signs, or the blowing-soap-bubbles technic, the speech therapist works with each child to overcome his particular difficulties in coordination.

There are two regular classrooms, one for beginners, the other for the more advanced. The youngsters study regular school subjects, but with a difference. The classroom for the more advanced group has its blackboard, flowers, books, wall exhibits of composition and finger painting. But it also has small tables of varying heights, and a special treatment table within which the athetoid child who cannot control his movements may be completely supported while he tries to learn to write, a crayon tied to his hand. The children also work with a typewriter to strengthen finger coordination, and try to sing or dance to phonograph music. One may push around a heavily weighted doll carriage, which gives him steadying support.

The unit's teachers, the speech and physical therapist, follow a careful routine worked out for each child after the part-time physician has prescribed his braces and determined his disabilities. A card for one child reads: "Independent in feeding, dependent in toilet, wears braces, must be supported under one arm in walking, right-handed, must be helped with one sleeve in undressing, right-handed." Mothers, who are enthusiastic over the program, help with dressing and undressing, serving lunch, and getting the youngsters from one room to another. Each child follows his own schedule of classwork, speech, and physical therapy.

In the physical therapy room the youngsters improve their coordination by the use of such equipment as parallel bars, metal skis with attached poles, specially built walking shoes. There are exercise mats and cots with gay blankets for rest periods.

The teamwork which achieved the program runs it. The Association for the Aid of Crippled Children covered initial heavy ex-

penses with a grant of $25,000. The Board of Education supplies space, equipment, and transportation. Screening of applicants for the school is done by the Division of Physically Handicapped of the Department of Health. The Queensboro Council for Social Welfare and the Queens Chapter, Cerebral Palsy Society of New York City, are going on with the all-important job of making the community understand the promise of such programs.

The unit, which will have a maximum enrollment of twenty-five by September, is small. But it marks another milestone. And city authorities, concerned over the thousands of cerebral palsied children whose needs are now unmet, will follow the experiment closely with a view to setting up units in other parts of the city.

"FOOD AND PEOPLE"

The universal problem of food shortage and how to solve it has been chosen by the UN Educational, Scientific and Cultural Organization as a topic for worldwide discussion. UNESCO in cooperation with UN's Food and Agriculture Organization and other agencies has prepared a "Food and People" guide and fact sheet for use of discussion groups and for the preparation of magazine articles and radio programs.

The discussion guide poses the problem: the world food supply lags behind a world population increase of 20,000,000 yearly; only one third of the world's people get enough to eat; yet science if put to work could produce the needed food.

UNESCO hopes that groups of citizens the world over may use these background materials for forums on the food problem. Then, as the fact sheet points out: "As citizens, joining with other citizens, we can support national and international programs that promise to bring food and people into eventual balance."

Also available as source material on this subject are six other UNESCO pamphlets. These are: *UN Sets the Table* by Peter Kihss, 25 cents; *Are There Too Many People?* by Alva Myrdal and Paul Vincent, 50 cents; *Food and the People* by Margaret Mead, 25 cents; *Distribution of the World's Food* by Stefan Krolikowski, 25 cents; *Food and Social Progress* by Andre Mayer, 25 cents; *Food, Soils and People* by Charles E. Kellogg, 60 cents. These may be secured from UNESCO, 405 East 42nd Street, New York 12.

NEW LIST OF SCHOOLS

A new national list of state-approved schools of nursing has been published in booklet form by the Committee on Careers in Nursing.

In addition to listing state-approved schools, the booklet gives data on types of program, requirements, degrees, et cetera. There is a separate listing of schools which have been accredited by the National Nursing Accrediting Service. The ratings given schools under the 1949 Interim Classification are also given. (See PUBLIC HEALTH NURSING, October 1949, p. 546.)

Copies of the booklet have been mailed to the nearly 28,000 high schools of the nation by the U. S. Office of Education. The Committee on Careers in Nursing has distributed copies to schools of nursing, hospitals, and recruitment groups taking part in the 1950 drive to enroll 50,000 new students.

Single copies are available free of charge. Additional copies are 10 cents each or $7.50 per 100.

MOBILIZATION TO PREVENT BLINDNESS

Leaders of business and civic groups joined professional workers interested in the prevention of blindness at an all-day meeting in New York on May 24th. A program built around the theme, Mobilization to Prevent Blindness, was sponsored by the National Society for the Prevention of Blindness and the American Academy of Ophthalmology and Otolaryngology.

Dr. Franklin M. Foote, executive director of NSPB, said that each week 420 of our fellow Americans lose their sight. What makes this tragedy especially distressing is that fully 50 percent of these persons need not become blind, if the knowledge now available were promptly and adequately ap-

plied. Experimentation is carried on continuously and progress made. The new drug ACTH is being tested against glaucoma and in the treatment of eye inflammations. The antihistamine drugs are effective in curing certain eye allergies.

Other gains in fighting blindness were reported. Since 1935 there has been a 25 percent decrease in blindness caused by eye injuries among children. Doubtless the regulation of the sale of fireworks for Independence Day celebrations, which in the past resulted in 500 injuries each July, has much to do with this.

Unfortunately the picture for congenital blindness is not so bright. Dr. Leona Baumgartner, associate chief, Children's Bureau, Federal Security Agency, told that blindness among children due to prenatal causes has increased 17 percent since 1936.

WHO ASSISTS IN DISASTER

Immediately after hearing about the violent earthquake which hit the city of Cuzco in Peru on May 21st, the Pan American Sanitary Bureau, regional office of World Health Organization, cabled its representative in Peru to offer any necessary help. Dr. Anthony Donovan, chief of the PASB/WHO office in Lima, requested chlorinated lime for purifying water supplies, DDT dusters, hypodermic syringes and needles, 10,000 doses of typhoid-paratyphoid vaccine, and equipment for intravenous feedings and blood transfusions. These were flown to Peru.

It will be recalled that a similar type of help was flown to Ecuador last year when that country suffered a devastating earthquake.

COMMITTEE FOR SCHOLARSHIPS

A check for $3,000 for student scholarships was presented to the Cornell University-New York Hospital of Nursing by its Committee for Scholarships on the school's 73rd anniversary. In the past three years, this lay committee of women has raised a total of $7,400 for the scholarship fund of the school.

In accepting the check, Miss Virginia M. Dunbar, dean of the school of nursing, announced that several scholarships will be offered this fall to entering students as well as to those already in the school.

The committee, which has a membership of 115 women in New York, was originally organized in 1940 as a Red Cross unit. In 1947, the group reorganized with the new purpose of encouraging well qualified young women to enter nursing.

EUTHANASIA

A resolution formally condemning euthanasia was adopted by the World Medical Association at the April session of its Legislative Council in Copenhagen, Denmark.

The association, which represents more than 500,000 physicians of forty nations, denounced the practice several years ago at Geneva as contrary to its formal declaration and code, which stipulate that: "A doctor must always bear in mind the importance of preserving human life from the time of conception until death."

NEW ASSOCIATION

The School Nurses Association of Connecticut was formed in May. Mrs. Ella Bray, supervisor of school nurses in Torrington, was elected president. As a first activity the association in cooperation with the Connecticut State Department of Education sponsored a one-day workshop on the problems of impaired hearing.

MARY M. ROBERTS' FELLOWSHIP

The Board of Directors of the American Journal of Nursing Company announces with pleasure the establishment of the Mary M. Roberts' Fellowship. The purpose of the award is "to assist a qualified professional nurse to prepare herself in the technical aspects of writing about nursing and nursing education for professional and lay publications."

One of the requirements for candidacy is a specially prepared manuscript on some subject pertaining to nursing. The fellowship will provide a sum of $2,500 to $4,000, the exact amount to be determined by the Award Committee, for one academic year of study in a college or university.

If interested, write to "Fellowship," *Ameri-*

can Journal of Nursing, 1790 Broadway, New York 19. Awards will be made in the late summer.

SAFETY CONFERENCE AWARDS

Annual Merit Awards, honoring local groups for exceptional service to home safety education, will be given annually by the Home Safety Conference, the first at the 1950 National Safety Congress. Award winners will be chosen by a panel of judges.

The awards are not competitive. Any organization which has a program of home accident prevention is invited to apply. To secure a Merit Award report form, write to the Home Safety Division, National Safety Council, 425 No. Michigan Avenue, Chicago 11.

Besides giving national recognition to outstanding local achievement, it is hoped that the awards will stimulate wider interest in home safety programs.

SUMMER INSTITUTES

A summer institute on "The Geriatrics Program" will be held at Loyola University, September 11-13. Designed primarily for the public health nurse but open to all interested professional personnel, it will center around nursing responsibility in programs for older people.

On September 13-15, the university is giving another institute on "The Cancer Program," designed to give nurses recent information, materials, and methods in planning nursing programs in the cancer field.

The fee is $10 for each institute. Application should be made to Miss Essie Anglum, Chairman, Department of Public Health Nursing, Loyola University, 820 N. Michigan Avenue, Chicago 11, Illinois.

LEMUEL SHATTUCK AWARD

Dr. Charles-Edward Amory Winslow, professor emeritus of public health, Yale Medical School, was given the first "Lemuel Shattuck Award" at the 60th anniversary meeting of the Massachusetts Public Health Association in Boston. Dr. Winslow is editor of the *American Journal of Public Health and The Nation's Health.*

The award, for distinguished service by a New Englander in the field of public health, was made on the 100th anniversary of the pioneer Shattuck's "Report of the Sanitary Commission of Massachusetts." This report eventually became the blueprint for public health programs the country over.

NEW ANA AND NLNE OFFICERS

At the Biennial Convention, announcement was made of the election of Mrs. Elizabeth K. Porter as president of the ANA. Mrs. Porter, who succeeds Pearl McIver, is professor of nursing and director of advanced programs in nursing education at Frances Payne Bolton School of Nursing, Western Reserve University. Janet Geister, Mrs. Bethel J. McGrath, and Lucy D. Germain were re-elected, first and second vice-presidents and treasurer respectively. Agnes Ohlson is the new ANA secretary.

The NLNE announces the reelection of Agnes Gelinas as president and Henrietta Doltz as treasurer.

NURSE TO WHO CONFERENCE

Mrs. Lillian B. Patterson attended the third meeting of the World Health Organization in Geneva, Switzerland, in May. She was advisor to the U. S. delegates and also conferred with nursing representatives from other countries. Mrs. Patterson will become dean of the University of Washington School of Nursing in the fall. She has been on the faculty of the university for some time. A member of the NOPHN section: the Collegiate Council on Public Health Nursing Education, Mrs. Patterson is also a member of the ANA Board of Directors.

● Yale University Department of Public Health announces a new program of study in occupational health to begin in September 1950. The course is open to nurses who have a bachelor's degree—as well as physician, engineers, and chemists—and leads to a M.P.H. or M.S. degree.

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